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VOLUME XV

January-December, 1974

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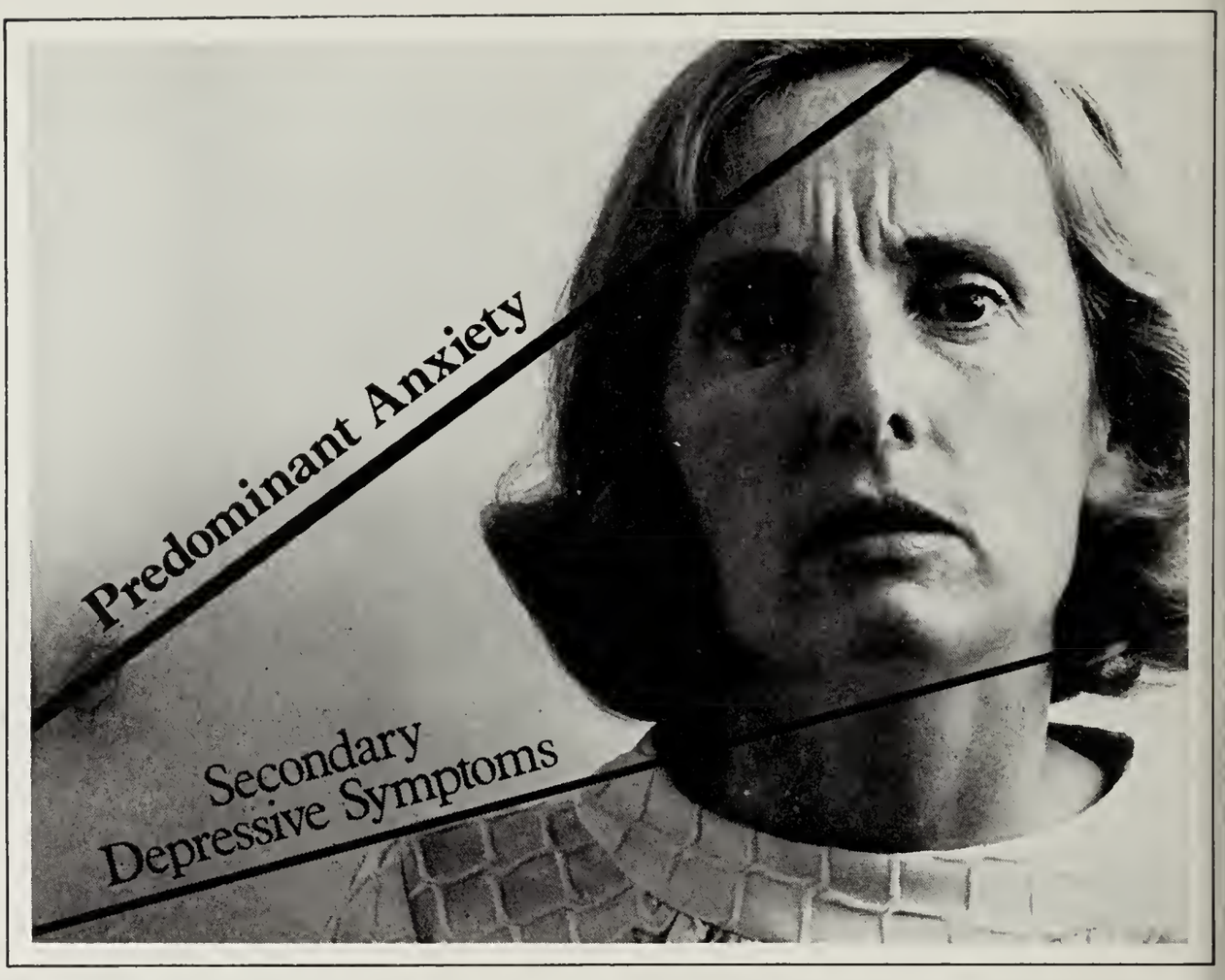
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This Month . . . Coronary Artery Disease, Pesticides, Public Health, Internal Medical Audit, Bipartite Patella

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Volume XV
Number 1
January 1974



JOURNAL of the Mississippi
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NEWSLETTER

January 1974

Dear Doctor:

A new planning program for the AMA is underway. Six "missions" that represent a general classification of AMA activities will be used as a framework for the system. Developed by the AMA's Council on Long Range Planning and Development and the Battelle Laboratories of Columbus, Ohio, the planning system was approved by the Board of Trustees in April and by the House of Delegates in June.

> For each mission the Board appointed a mission group to act as a communications link between it and the various councils, committees and staff units. Each group will be headed by a member of the Council on Long Range Planning and Development and have a trustee serving as advisor.

The Association now has available a toll free telephone number for use by member physicians, according to Charles L. Mathews, MSMA Executive Secretary. The number is 800-222-8313. Members of the headquarters staff will be on hand to answer questions weekdays from 8:30 a.m. to 4:30 p.m.

Travelers Medicare has announced a series of one day meetings for medical assistants to be conducted throughout the state in January. The meetings, designed particularly for physicians' office personnel, will deal with new Medicare services, claims procedures and allowances. Invitations are being sent to each M.D.'s office.

In an effort to inform physicians about the growing malpractice claim problem, The St. Paul Insurance Companies will begin publication of a "Malpractice Digest" this month. The digest will be sent to all policyholders. St. Paul is one of the country's leading professional liability insurers.

The AMA has produced a new AMA-PSRO color audio slide presentation designed to explain Professional Standards Review Organizations and AMA action. For information about obtaining the slide presentation, write Executive Secretary, Mississippi State Medical Association, 735 Riverside Drive, Jackson, Mississippi 39216.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Suicide Prevention Booklet Published

Throughout the world, approximately 1,000 people kill themselves every day. More men than women commit suicide and the man most apt to take his life is white, middle-aged or older, and has been separated from a loved one or is single.

These facts and the design of effective suicide prevention programs are discussed in a booklet, *Suicide Prevention in the 70's,* produced by HEW's National Institute of Mental Health.

Suicide Prevention in the 70's is a collection of committee reports resulting from a Task Force Conference which took place in January 1970. Some 50 leaders and students in the field of suicide prevention, self-destructive behaviors, dying, and bereavement met for three days to share their expertise and establish new directions and priorities for the present decade.

Six task force committees dealt with topics and issues vital to future directions for the field of suicide prevention and crisis intervention. The committees prepared the reports which deal with death and self-destructive behaviors, education and training, research, treatment approaches, delivery services, and classification and nomenclature.

According to Dr. H. L. P. Resnik, chief of the Mental Health Emergencies Section, "The study of suicidal behavior came of age in the Sixties. The challenge of the Seventies resides in our ability to render intervention and rescue services directly to suicidal people wherever they are. However, the problem only begins then. Effective suicide prevention efforts necessitate the expansion of outreach, aftercare, and mobile emergency mental health services in every community.

"This publication offers clearcut recommendations to help implement and improve the delivery of such services at the community level. Hopefully, they will serve as guidelines for the integration of such services into a comprehensive emergency medical service capable of responding to life threatening crises whether medical or psychiatric."

Suicide Prevention in the 70's is available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at $1.00 per copy.

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DATELINE

Riddell Memorial Fund Established

Winona, Miss. - The family of Dr. Mal S. Riddell, Jr., has established a scholarship fund in memory of their husband and father. The scholarship will be awarded each year to a deserving student from Winona High School to be used at the college of his or her choice. Donations to the Mal S. Riddell, Jr., Memorial Scholarship may be mailed to the Bank of Winona, Merchants and Farmers Bank of Winona or Winona High School.

Federal Rules of Evidence

Washington, D.C. - The House Judiciary Committee has reported H.R. 5463, relating to the rules of evidence applicable to actions in federal courts. Committee rejected an earlier proposal which would have, in effect, eliminated the traditional physician-patient privilege in federal actions. The committee made no provision for a proposed privilege preventing disclosure of confidential communications in psychotherapy.

MSMA Gets CME Accreditation

Jackson, Miss. - The AMA Council on Medical Education has approved the Mississippi State Medical Association as an accrediting agency for continuing medical education (CME) in Mississippi, according to the MSMA Council on Medical Education. Programs of local scope and focus are to be developed for accreditation. The community hospital can now become a center for postgraduate education.

Chiropractic School Certified

St. Louis, Mo. - Becoming the first chiropractic school to qualify as an "institution of higher learning," the Logan College of Chiropractic used the new three-institution procedure of the U.S. Office of Education. Procedure allows an institution to become certified without having been accredited by a recognized accrediting agency, if its credits are accepted on transfer by three nationally accredited institutions.

Noise Threatens Health, Work

San Diego, Cal. - Noise does more than threaten your hearing. Studies show it may also raise blood cholesterol, contract blood vessels, raise blood pressure and possibly bring on early heart attack. What's more, says Dr. Maurice Schiff of the University of California, studies of workers show it can affect work and cause mistakes. The otolaryngologist published the list of physical effects of noise in Transactions.

Alcoholism Council, Society Merge

Merger of the National Council on Alcoholism (NCA) and the American Medical Society on Alcoholism (AMSA) has been announced.

This is believed to be the first merger of its kind in the public health field.

Dr. Frank A. Seixas, NCA medical director, and Dr. Maxwell Weisman, AMSA president, said that the action is the signal for a massive campaign to encourage more doctors and hospitals to treat alcoholics.

In a joint statement, Drs. Weisman and Seixas said: "The number of doctors prepared to treat alcoholism is grossly inadequate when one considers that alcohol is America's number one drug problem and alcoholism a health threat surpassed only by cancer and heart disease.

"Doctors and medical schools have been criticized for their apparent neglect of the alcoholic patient. Much of this criticism has been unfair. Information has not been available to the medical community in any organized manner. It has worked in the dark. However, the merger of our two groups will provide the manpower and organization necessary to correct that situation. We will give doctors and schools the data and service so many of them have been asking for."

Drs. Seixas and Weisman said that the need for a large-scale professional education effort is reflected in the fact that the four-year curriculum for most medical schools now includes only a one-hour lecture on alcoholism.

"Doctors are entering private practice totally unprepared to deal with a disease they will encounter on a daily basis," they said.

The two alcoholism authorities added: "We hope to effect a change in attitude among some medical practitioners. We shall attempt to show them that alcoholism is a respectable disease and not a moral weakness. This kind of attitude prevents some doctors from acquiring and using knowledge. The result is a needless loss of lives.

"Many doctors now treat the complications of alcoholism and not the disease itself. A doctor will deal with a bad liver but fail to identify alcoholism as the cause. We hope to bring physicians to the point where they will tell a patient

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that he has alcoholism instead of sugar-coating the issue. They tell a cancer patient that he has cancer. They should tell an alcoholic that he has alcoholism. Otherwise, how can they treat him properly?"

Under terms of the agreement, AMSA becomes NCA's component organization in the medical field. It will assume a consulting and advisory role in establishing the accuracy of NCA's policy statements on medical issues.

Dr. Maxwell Weisman, AMSA president, becomes a member of the executive committee of NCA's board of directors. AMSA will nominate new members for NCA's medical affairs committee chaired by Dr. Luther Cloud. George C. Dimas, NCA executive director, assumes added duties as executive director of AMSA.

The National Council on Alcoholism is the only national voluntary health organization devoted to alcoholism in the United States today. Founded 29 years ago, it has served as a focus for both lay and professional volunteers in providing public health information, counseling and referral centers and support for needed legislative and institutional change to promote better understanding of alcoholism and its treatment. It has 160 autonomous affiliates and associates throughout the United States. Its medical department serves as a center for the dissemination of professional information, promotes scientific training in alcoholism, and encourages research and treatment efforts.

The American Medical Society on Alcoholism was founded in New York City in 1954 as a local discussion group to increase interest in alcoholism among physicians. The society was incorporated in New York State in 1962. In 1967 it became a national organization. It publishes *The Physician's Alcohol Newsletter,* a quarterly review of progress in the medical sphere.

AMSA and NCA have had a history of cooperation. NCA has provided a forum for AMSA at annual meetings. It has promoted the distribution of *The Physician's Alcohol Newsletter.* Five presidents of NCA have been AMSA members. The two medical directors of NCA have come from the ranks of AMSA. Many AMSA members have spoken at NCA forums and conferences and have served on the boards of its national and affiliate organizations.

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College of Surgeons Plans Spring Meeting

Continuing a major change in its long-range educational program, the American College of Surgeons will sponsor its second annual four-day spring meeting in Houston Mar. 25-Mar. 28, 1974, at the Albert Thomas Convention Center and the Hyatt Regency Hotel.

The meeting will provide eight postgraduate courses, some of which will involve plenary sessions, followed by splitting into smaller groups to facilitate participation and discussion. The precise format will be determined by the presiding chairman. A surgeon may choose one of four courses during the first two days of the meeting, and select another from four other offerings in the second two days.

The nine-hour postgraduate courses will be supplemented by two days of symposia, panels, lectures and motion pictures.

Industrial exhibits will be open in the Albert Thomas Convention Center Mar. 25-27, 1974, from 9:30 a.m. to 5 p.m.

The postgraduate courses will cover: fluids and electrolytes, cardiovascular surgery, cancer, plastic surgery, shock, gastrointestinal surgery, surgery of the hand and urologic surgery.

Fees for the postgraduate courses, approved by the American Medical Association for credit as continuing education courses, is $40.00 for all registrants, manual included. Registration for this meeting is a prerequisite for registering in the postgraduate courses.

Registration for the meeting will be free of charge to Fellows of the college whose dues are paid through 1973, members of the ACS Credentials Group, and surgical residents. Non-Fellows, applicants for Fellowship and Fellows whose dues have not been paid, pay $50.00. Non-Fellows in the Federal Services (fulltime) pay $30.00.

Registered nurses and interns who present proper credentials may register free for the general sessions and exhibits, but are not eligible for the postgraduate courses.

Housing and registration forms are available from the ACS, 55 East Erie Street, Chicago, Ill. 60611.

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New JCAH Brochures Explain Accreditation

The Joint Commission on Accreditation of Hospitals (JCAH) has announced the availability of three new consumer oriented brochures that explain accreditation.

Titled "An Accredited Hospital," "An Accredited Long Term Care Facility," and "An Accredited Psychiatric Facility," they tell consumers what a facility has accomplished by achieving accreditation.

Each pamphlet contains information the Joint Commission believes an accredited facility would want consumers and other interested publics to know.

Included are sections that describe the responsibility and accountability of facilities for the kind of care they furnish; how a facility becomes accredited; why a facility, its personnel and its staffs should want to become accredited; and a short history of JCAH. Their size, 8½" x 4", easily fits into the most commonly used business envelope.

According to the Joint Commission there are many possible uses for the two-color booklets. For example, facilities could:

- distribute them to patients,
- place them where the general public can read them,
- mail them to people in their community, and
- distribute them to officials and others as an educational effort.

Prices for the brochures range from $14.00 for 100 copies to $10.00 per 100 copies in quantities of 1,000 or more. There is an additional charge for imprinting.

The Joint Commission has set a policy that quantity orders will be accepted only from JCAH accredited facilities. Single copies are available at no charge from Public Information, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Ill. 60611.

The Joint Commission is a non-governmental, not-for-profit organization that sets accreditation standards and provides survey services through which health care facilities can measure and improve the quality of services they provide. It has programs for the accreditation of hospitals, long term care and psychiatric facilities, and facilities for the mentally retarded.

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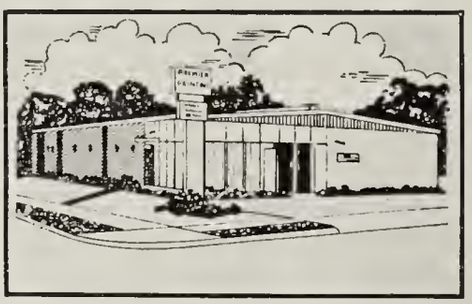
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1974, Vol. XV, No. 1

ORIGINAL PAPERS

Changing Concepts of Coronary Artery Disease

QUINTON H. DICKERSON, JR., M.D.
Jackson, Mississippi

Coronary atherosclerosis with its clinical manifestations of angina pectoris and acute myocardial infarction is presented. The author discusses diagnostic methods including exercise, testing and coronary angiography. The current state of medical and surgical management is reviewed and compared.

THE PAST DECADE has witnessed an overwhelming resurgence of interest in coronary atherosclerosis and its clinical manifestations of angina pectoris and acute myocardial infarction. The development of coronary angiography by Sones and Shirey, the emergence of coronary care units for treatment of complications of acute myocardial infarction, and the application of newer surgical techniques for direct myocardial revascularization by Favaloro and others have been factors contributing to this interest. There has been the attendant study of exercise and its relation to diagnosis and treatment of coronary artery disease, categorization of serum lipid abnormalities with specific dietary and drug treatment, and the refinement of drug therapy for treatment of angina pectoris and arrhythmias associated with acute myocardial infarction. This review will attempt to focus on current concepts in diagnosis and hemodynamic changes in occlusive coronary artery disease and recent developments in medical and surgical treatment.

The deposition of small fatty streaks of lipid material in the arterial wall occurs in virtually all humans regardless of genetic and dietary factors. The reasons for the progression of this extremely common and yet benign pathologic change to occlusive atherosclerosis remain unclear. Despite this, those risk factors which are associated with the statistical increase in likelihood of the development of significant atherosclerosis have been clearly determined. The manipulation of diet has been utilized to control serum lipids, mainly beta lipoproteins (cholesterol being the easiest and most often measured component), and has been proposed for the prevention of atherosclerosis in normal persons and in treatment of persons with ischemic heart disease. The rationale for this dietary treatment has been the striking epidemiological evidence of increased risk of coronary artery disease paralleling serum cholesterol levels. The commonly utilized classification of hyperlipoproteinemias proposed by Friedrickson and Levy has resulted in an increased interest in the level of serum triglyceride, a primary component of pre-beta lipoprotein, as well as cholesterol as related to coronary artery disease.[1] Specific diets and antilipemic drugs are available for returning elevated levels of these lipid components of the blood to the normal range. The ultimate effect of this therapy on the development of new atherosclerotic lesions or the progression or regression of old lesions is unknown at present. A significant

Presented before the Section on Medicine, Mississippi State Medical Association, Biloxi, May 2, 1973.

lipoprotein abnormality is present in over one-half of patients with angiographically documented coronary artery disease (see Table I). This percentage increases in patients below the age of 40, and in women under 40 years of age with coronary artery disease, Type II hyperlipoproteinemia is extremely common.[2, 3] The degree and location of coronary arterial obstruction occurring in patients with a lipid abnormality are no different from that occurring in patients with normal lipoproteins.[4] The risk factors of genetic predisposition, abnormal glucose metabolism, systemic hypertension, obesity, cigarette smoking, physical inactivity, and emotional stress are well known.

TABLE I

Occlusive coronary artery disease	50 Per Cent	Abnormal lipoproteins Normal lipoproteins

Angina pectoris results from a disparity between myocardial oxygen requirements and supply. Those factors determining the requirement of oxygen by the myocardium, namely heart rate, systolic ventricular pressure, and myocardial contractility, must be taken into account in diagnostic and therapeutic approaches (see Table II).[5] Angina pectoris remains a clinical syndrome and its diagnosis is dependent upon the patient's ability to understand and communicate his symptoms and the physician's expertise in extracting an accurate history. In patients who give a typical history of anginal pain and in whom left ventricular outflow obstruction is not present, significant occlusive coronary disease is present in about 90 per cent. Somewhat less than one-half of those patients who present a suggestive but atypical history will be found to have significant coronary disease.[6]

TABLE II

MAJOR FACTORS DETERMINING MYOCARDIAL OXYGEN CONSUMPTION

Heart rate
Intramyocardial tension
Ventricular pressure
Ventricular volume
Myocardial mass
Contractile state

Exercise is a simple means of increasing myocardial oxygen requirement by increasing heart rate and augmentation of systolic blood pressure. The introduction of the Master two-step test has been followed by various graded exercise tests using a treadmill or a bicycle ergometer in an attempt to induce angina and/or ischemic ST segment change on the electrocardiogram in patients with suspected occlusive coronary artery disease. Numerous studies have compared the results of exercise electrocardiography with the findings of coronary angiography. Specificity, that is a negative exercise electrocardiogram agreeing with a normal coronary angiogram, has been in the range of 90 per cent for most graded exercise tests. On the other hand, its sensitivity, that is development of ischemic ST segment change with exercise concurring with findings of significant coronary occlusive disease at angiography, has been in the range of 40-50 per cent for the double Master test and somewhat higher at 70-80 per cent for a graded exercise test utilizing the treadmill or bicycle ergometer (see Table III).[7]

TABLE III

CORRELATION OF EXERCISE ELECTROCARDIOGRAPHY WITH CORONARY ANGIOGRAPHY

	Sensitivity (True Positive) (Per Cent)	*Specificity (True Negative) (Per Cent)*
Double master's	40-50	90
Graded exercise (treadmill or bicycle)	70-80	

The introduction of coronary cineangiography by Sones and Shirey has been followed by the development of techniques and catheters by Judkins, Bourassa, Amplatz, and Castillo.[8, 9] The coronary angiogram is at present the most precise technique for detection of the presence of occlusive coronary atherosclerosis in the living human. That it may underestimate the extent of disease present has been demonstrated recently by comparison of antemortem coronary angiograms with postmortem findings.[10] The indication for coronary angiography is clear in patients who have had a myocardial infarction and continue to exhibit angina pectoris, in patients with moderately severe angina without a history of infarction, in patients with unexplained heart failure or arrhythmia, and in patients with aortic valve disease and angina. Most coronary angiographers would, in addition,

feel that the study is indicated in patients with crescendo ("pre-infarctional") angina pectoris, as part of a postoperative evaluation to determine patency of bypass grafts, or in persons with electrocardiographic abnormalities in whom a definite diagnosis is necessary for employment purposes (such as airline pilots) or insurance purposes, patients with a previous myocardial infarction without residual angina, especially younger patients, and patients with undiagnosed anginal-like chest pain with non-specific EKG changes who are problems in management. Other indications which have been proposed with varying degrees of acceptance include patients without myocardial infarction or angina pectoris but with recent onset of electrocardiographic abnormalities, patients with acute myocardial infarction and cardiogenic shock, and patients who are at a high risk of coronary disease because of gross lipid or other genetic abnormalities (see Table IV).[11, 12]

TABLE IV

INDICATIONS FOR CORONARY ANGIOGRAPHY

Previous myocardial infarction with angina pectoris
Moderately severe angina without infarction
Unexplained heart failure or arrhythmia
Aortic valve disease and angina
Crescendo angina
Postoperative evaluation
Unexplained abnormal EKG
Previous myocardial infarction without angina (younger patient)
Undiagnosed chest pain with EKG abnormalities
Recent onset of abnormal EKG
Cardiogenic shock
High risk asymptomatic patients

The treatment of angina pectoris, both medical and surgical, is directed toward restoring an optimum balance between myocardial oxygen supply and demand. General measures which should be employed for all patients include achievement of ideal body weight, abstinence from tobacco, the adoption of an exercise program for physical conditioning and the avoidance where possible of those specific physical activities known to precipitate or aggravate anginal episodes and treatment of congestive heart failure or hypertension when present (see Table V).

Abnormalities of lipid or carbohydrate metabolism should be regulated by diet or appropriate drugs although it is yet unproven that returning abnormal serum lipids to normal reduces the risk of development of coronary disease. While there has been no clear demonstration of increase in coronary collateral circulation associated with an exercise program, physical conditioning does result in a decrease in frequency of angina, an increase in self esteem, and the development of a more positive attitude.[13] The peripheral response in adaptation to physical training results in the ability to perform a greater work load at a lower heart rate and at a lower total oxygen cost.[14]

TABLE V

TREATMENT OF ANGINA PECTORIS—
GENERAL MEASURES FOR ALL PATIENTS

Achievement of ideal body weight
Abstinence from tobacco
Exercise program for physical conditioning
Avoidance of activities aggravating symptoms
Treatment of CHF of hypertension

Sublingual nitroglycerin remains the nitrate of choice for use in patients with angina pectoris. Its mechanism of action of relief of angina is thought to result from its pharmacologic effect of smooth muscle relaxation with consequent reduction in vascular tone resulting in diminished peripheral resistance and pooling of venous blood with decreased cardiac output, stroke volume and ventricular volume. These factors decrease the external work performed by the left ventricle, lead to the reduction in myocardial oxygen consumption, despite the increase in resting heart rate produced by nitroglycerin. The role of long acting nitrates in the treatment of angina pectoris remains controversial. There is little evidence that those agents taken orally are of value and other sublingual nitrates may have a duration of effectiveness not substantially longer than sublingual nitroglycerin.[15, 16] There has been a recent renewed interest in the application of nitroglycerin topically as an ointment. Enhancement of exercise performance as a measure of effectiveness has been demonstrated up to three hours after administration.[17] The introduction of the beta adrenergic blocking agent propranolol has been a significant advance in the pharmacologic treatment of angina pectoris. Propranolol decreases myocardial oxygen demand by several mechanisms. The normal augmentation in myocardial contractility and heart rate associated with sympathetic stress and exercise is blocked.[18] The drug may also be capable of altering distribution of coronary flow and improving perfusion in an ischemic area.[19] The effective dose range is variable and some patients may require large doses for adequate beta blockade. A control double blind study with four dose

levels of propranolol and placebo has shown a progressive reduction in the number of angina attacks with increasing dosage of propranolol.[20]

Numerous surgical procedures have been advocated for myocardial revascularization. The current operation is direct anastomosis of a saphenous vein graft from the ascending aorta to a coronary artery distal to an occlusive lesion. This type of bypass surgery is theoretically more rational than earlier procedures, is similar in its hemodynamic approach to proven procedures in other vascular beds, and has provided symptomatic relief for many patients. A new variation of this bypass procedure has been the direct end to side anastomosis of the internal mammary artery into the coronary arterial tree. Other surgical procedures utilized for complications of myocardial ischemia include resection of ventricular aneurysm in an attempt to improve left ventricular performance or abolish resistant ventricular arrhythmias, mitral valve replacement for mitral regurgitation due to ischemic disease of the mitral valve apparatus including the left ventricular wall, and emergency repair of a perforated ventricular septum from an acute myocardial infarction.[21]

The indications for saphenous vein bypass grafting have evolved as the procedure has been developed in its application. Initially the procedure was advocated for patients with intractable angina. There are few patients with truly intractable angina. The number of patients who will continue to have frequent and incapacitating episodes of angina despite a thorough medical regimen including weight reduction, exercise, nitroglycerin and propranolol is small. The bypass grafting procedure is currently being applied to patients with angina which is moderate or severe in frequency and which is variably controlled depending on the medical regimen applied. In addition, increasing numbers of patients with "crescendo," unstable, or "pre-infarctional" angina are being treated surgically. It is these two groups that the results of medical and surgical treatment in terms of immediate and long range improvements, morbidity, and mortality should be compared. The application of this surgical procedure to patients with minimal symptoms and a severe lesion which is anatomically favorable to surgery and its application to patients in cardiogenic shock is difficult to evaluate at this time. The results of the small number of patients in this latter category treated surgically are encouraging considering the poor prognosis of patients in cardiogenic shock.[22] In addition the bypass graft procedure has been utilized as treatment for intractable ventricular arrhythmia and for congestive heart failure.

It is now generally accepted that saphenous vein bypass grafting is an effective procedure for relief of angina pectoris. The question of whether the operation alters the natural history of coronary artery disease and prolongs life is at present in the process of being answered. In considering the results of bypass surgery for treatment of patients with moderate or severe angina a comparison should be made with the results of a similar group of patients treated medically. Unfortunately there is little data currently available regarding the medical treatment or natural history of coronary artery disease in terms of its progression and annual mortality. However, recent reports from the Cleveland Clinic regarding 1,000 patients treated surgically indicate a 79 per cent survival rate in a group of 73 patients followed up to five years. A similar group of medically treated patients experienced a 65.8 per cent five year survival rate (see Table VI). A larger group of 269 surgical patients followed at four years had an 87 per cent survival rate. These figures include an overall 4 per cent hospital mortality rate. The annual attrition rate for patients treated surgically was 4.1 per cent compared to 6.8 per cent for non-operated patients in this series.[23]

TABLE VI

CORONARY ARTERY DISEASE
FIVE YEAR SURVIVAL RATES
(CLEVELAND CLINIC)

Non-Operated Patients	*Surgical Treatment*
65.8 per cent	79.4 per cent*

* Includes 4 per cent hospital mortality.

The application of this procedure to patients with crescendo angina or unstable angina pectoris (pre-infarctional angina or impending myocardial infarction) is being evaluated in several centers. A wide divergency of results is being reported probably on the basis of the lack of standardized criteria for inclusion of patients in this category. In addition, there is a wide range of survival rate in patients treated medically with this syndrome in differing centers, probably for similar reasons. The Cleveland Clinic reports a 5.6 per cent overall mortality in 89 patients undergoing emergency myocardial revascularization.[24] In a group of 57 consecutive patients presenting with unstable

angina at Johns Hopkins the surgical mortality was 22 per cent in 40 patients undergoing surgery for this syndrome and a 13 per cent mortality was noted in 15 patients treated medically.[25] The Stanford Medical Center has reported 67 patients who met their criteria for "pre-infarctional angina" and were treated surgically with an operative mortality of 10.4 per cent.[26] There remains little information regarding the survival rate of patients treated medically with this syndrome. However, a report from Edinburgh of 167 patients with unstable angina treated medically indicated a mortality rate of 2.4 per cent which included follow-up for up to six months for the majority of the patients (see Table VII).[27] This mortality rate is within the range of the 2-4 per cent mortality currently accepted for elective direct myocardial revascularization. There is clearly a need for standardization of criteria for diagnosis.

TABLE VII

"PRE-INFARCTION" ANGINA
IN-HOSPITAL MORTALITY

	Treatment	
	MEDICAL	SURGICAL
Cleveland		5.6% (89)
Hopkins	13 % (15)	22 % (40)
Stanford		10.4% (67)
Edinburgh	2.4%* (167)	

* Includes 6 month follow-up for majority of patients. Number of patients in the series is indicated by parentheses.

The mechanisms by which coronary bypass grafting results in symptomatic improvement include the increase in myocardial perfusion and may occasionally be related to infarction of ischemic muscle.[28] The incidence of myocardial infarction associated with direct revascularization is difficult to measure by enzymatic or electrocardiographic criteria. However, various studies have indicated an incidence as low as 6 per cent and as high as 35 per cent.[29, 30] This wide variation may be explained on the difficulty of diagnosing myocardial infarction after coronary surgery and different criteria utilized by various investigators.

An overall long-term graft patency rate of approximately 80 per cent has been reported from several centers. Most graft closures take place within the first few months after surgery.[23] Important factors in determining long-term graft patency include the size of the native coronary artery into which the graft is anastomosed, the status of the distal vascular bed, i.e. distal run-off, and the intra-operative flow measurement.[31–33] Graft closure may manifest itself by the return of angina pectoris. Postoperative deterioration in left ventricular function with the development of congestive heart failure may be the result of myocardial infarction associated with surgery.

The changes which occur in the native coronary circulation after bypass grafting include progression of severity of proximal coronary artery disease such as total occlusion of a previous stenotic proximal lesion,[34] and, at least in the experimental animal, regression of intracoronary collateral vessels.[35] Those factors which increase the operative mortality include left ventricular dysfunction and congestive heart failure, extensive coronary artery disease, increased age, and presence of a recent myocardial infarction.[36] Symptomatic improvement after surgery is less likely in patients with severe abnormalities of left ventricular function, and extensive atherosclerotic disease.[37]

It now appears that patients with moderate or severe angina pectoris who are demonstrated to have one or more significant stenotic lesions in the proximal coronary arterial tree and with normal or near normal distal vessels, who do not have evidence of significant left ventricular dysfunction, and who have no other contraindications for surgery, have a high probability of benefit both in terms of the improvement in symptomatology and probably in longevity if surgically treated with coronary artery bypass grafting. The overall proven benefit from its application in the syndrome of crescendo or unstable angina pectoris is less definite but very likely. The procedure may have application in acute myocardial infarction with cardiogenic shock.

The future should bring advancement in the area of primary prevention of coronary atherosclerosis. Emphasis on a basic alteration in diet to one of a lower content of saturated fat and cholesterol, encouragement of physical activity, discouragement of smoking, and control of hypertension, abnormal carbohydrate and lipid metabolism where present, are necessary. At present it is estimated that 600,000 coronary deaths occur each year in the United States and the cost of the bypass operation in an uncomplicated case is in the range of $7,500. It is apparent that this ravaging disease is being treated in its end stage and in the future greater emphasis will have to be placed on early prevention. ★★★

515 St. Dominic Medical Offices (39216)

REFERENCES

1. Friedrickson, D. S., Levy, R. I. and Lees, R. L.: Fat Transport in Lipoproteins—An Integrated Approach to Mechanisms and Disorders. NEJM 267:32-44, 94-103, 148-156, 215-226, 273-281, 1967.
2. Heinle, R. A., Levy, R. I., Friedrickson, D. S. and Gorlin, R.: Lipid and Carbohydrate Abnormalities in Patients With Angiographically Documented Coronary Artery Disease. Am. J. Cardiol. 24:178-186, 1969.
3. Brown, D. F., Sosa, J. A. and Daudiss, K.: Hyperlipoproteinemia in 588 Patients With Angiographically Defined Coronary Artery Disease. Am. J. Cardiol. 31:123, 1973.
4. Stiles, G. L., Smith, R. F., Perry, J. M., Friesinger, G. C. and Sinclair-Smith, B. C.: Quantitative Coronary Arteriographic Measurements in Symptomatic Patients With or Without Lipoprotein (II and IV) Abnormalities. Am. J. Cardiol. 31:160, 1973.
5. Sonnenblick, E. H., Ross, J. and Braunwald, E.: Oxygen Consumption of the Heart, Newer Concepts of Its Multifactoral Determination. Am. J. Cardiol. 22:328-336, 1968.
6. Friedberg, C. K.: Some Comments and Reflections on Changing Interests and New Developments in Angina Pectoris. Circulation 46:1037-1047, 1972.
7. Redwood, D. R. and Epstein, S. E.: Use and Limitations of Stress Testing in the Evaluation of Ischemic Heart Disease. Circulation 46:1115-1131, 1972.
8. Judkins, M. P.: Selective Coronary Arteriography—A Percutaneous Transfemoral Technique. Radiology 89:815-824, 1967.
9. Bourassa, M. G., Lesperance, J., Campeau, L., Bois, M. A. and Saltiel, J.: Selective Coronary Angiography Using a Percutaneous Femoral Technique. Canadian Med. Assoc. J. 102:170-173, 1970.
10. Vlodaver, Z., Frech, R., Van Tassel, R. A. and Edwards, J. E.: Correlation of the Antemortem Coronary Arteriogram and the Postmortem Specimen. Circulation 47:162-169, 1973.
11. Sones, F. M.: Indications and Value of Coronary Arteriography. Circulation 46:1155-1160, 1972.
12. Baltaxe, H. A. and Levin, D. C.: Coronary Angiography—Its Role in the Management of Patients With Angina Pectoris. Circulation 46:1161-1172, 1972.
13. Kennedy, C. C., Spiekerman, R. E., Lindsay, M. I., Frye, R. L., Mankin, H. T., Cantwell, J. D. and Harbold, N. B.: Evaluation of a One Year Graduated Exercise Program for Men With Angina Pectoris by Physiologic Studies and Coronary Arteriography. Am. J. Cardiol. 31:141, 1973.
14. Hellerstein, H. K.: Exercise Therapy in Coronary Artery Disease. Bulletin N. Y. Acad. of Med. 44:1028, 1968.
15. Klaus, A., Zaret, B., Pitt, B. and Ross, R. S.: Comparative Evaluation of Sublingual Long-acting Nitrates in Angina Pectoris. Am. J. Cardiol. 31:142, 1973.
16. Aronow, W. S.: The Medical Treatment of Angina Pectoris—Long-Acting Nitrites as Antianginal Drugs. Am. Ht. J. 84:567-569, 1972.
17. Reichek, N., Goldstein, R. E., Nagel, M. and Epstein, S. E.: Sustained Effects of Nitroglycerin Ointment in Patients With Angina Pectoris. Am. J. Cardiol. 31:453, 1973.
18. Wolfson, S. and Gorlin, R.: Cardiovascular Pharmacology of Propranolol in Man. Circulation 40:501-511, 1969.
19. Becker, L. C., Fortuin, N. J. and Pitt, B.: Effect of Ischemia and Antianginal Drugs on the Distribution of Radioactive Microspheres in the Canine Left Ventricle. Circulation Res. 28:263-269, 1971.
20. Prichard, B. N. C. and Gillam, P. M. S.: Assessment of Propranolol in Angina Pectoris: Clinical Dose Response Curve and Effect on ECG at Rest and on Exercise. Brit. Ht. J. 33:473-480, 1971.
21. Mundth, E. D., Buckley, M. J., Daggett, W. M., Sanders, C. A. and Austen, W. G.: Surgery for Complications of Acute Myocardial Infarction. Circulation 45:1279-1291, 1972.
22. Sanders, C. A., Buckley, M. J., Leinbach, R. C., Mundth, E. D. and Austen, W. G.: Mechanical Circulatory Assistance. Current Status and Experience With Combining Circulatory Assistance, Emergency Coronary Angiography, and Acute Myocardial Revascularization. Circulation 45:1292-1313, 1972.
23. Sheldon, W. C., Rincon, G., Effler, D. G., Proudfit, W. L. and Sones, F. M.: Vein Graft Surgery for Coronary Artery Disease: Survival and Angiographic Results Among the First 1,000 Patients. Circulation Suppl. 11 45, 46:11-110, 1972.
24. Cheanvechai, C., Effler, D. B., Loop, F. D., Groves, L. K., Sheldon, W. C., Razavi, M. and Sones, F. M.: Emergency Myocardial Revascularization. Am. J. Cardiol. 31:125, 1973.
25. Conti, R., Brawley, R., Pitt, B. and Ross, R.: Unstable Angina: Morbidity and Mortality in 57 Consecutive Patients Evaluated Angiographically. Am. J. Cardiol. 31:127, 1973.
26. Miller, D. C., Cammon, D. S., Fogarty, T. J., Schroeder, J. S., Daily, P. O. and Harrison, D. C.: Saphenous Vein Coronary Artery Bypass in Patients With "Pre-Infarctional Angina." Circulation 47:234-241, 1973.
27. Fulton, M., Lultz, W., Donald, K. W., Kirby, B. J., Duncan, B., Morrison, S. L., Kerr, F., Julian, D. G. and Oliver, M. F.: Natural History of Unstable Angina. Lancet 1:860-865, 1972.
28. Griffith, L., Acheff, S., Humphries, J. O., Conti, R., Brawley, R., Gott, V. and Ross, R.: Mechanisms of Symptomatic Improvement After Coronary Bypass Graft Surgery. Am. J. Cardiol. 30:137, 1973.
29. Friedewald, V. E., Futral, J. E., Kinard, S. A., Diethrich, E. B. and Flinn, R. A.: Vectorcardiographic Changes Following Saphenous Vein Coronary Bypass Surgery. Am. J. Cardiol. 31:132, 1973.
30. Kansal, S., Roitman, D., Sheffield, L. T. and Kouchoukos, N. T.: Acute Myocardial Injury Following Aorto-Coronary Bypass Surgery. Am. J. Cardiol. 31:140, 1973.
31. Bouressa, M. G., Lesperance, J., Campeau, L. and Simard, P.: Factors Influencing Patency of Aorto-Coronary Vein Grafts. Circulation Suppl. 1 45, 46:179-85, 1972.
32. Walker, J. A., Friedberg, H. D., Flemma, R. J. and Johnson, W. D.: Determinants of Angiographic Patency of Aorto-Coronary Vein Bypass Grafts. Circulation Suppl. 1 45,46:1 86-90, 1972.
33. Lesperance, J., Bouressa, M. G., Viron, P., Campeau, L. and Saltiel, J.: Aorta to Coronary Artery Saphenous Vein Graft—Pre-Operative Angiographic Criteria for Successful Surgery. Am. J. Cardiol. 30:459-465, 1972.
34. Bousvaros, G., Piracha, A. R., Chaudhry, M. A., Grant, C., Older, T. M. and Pifarre, R.: Increase in Severity of Proximal Coronary Disease After Successful Distal Aorto-Coronary Graft—Its Nature and Effect. Circulation 46:870-879, 1972.
35. Cibulski, A. A., Lehan, P. H., Timmis, H. H. and Hellems, H. K.: Regression of Intercoronary Collateral Vessels in Mongrel Dogs After Coronary Bypass Grafting. Am. J. Cardiol. 31:480-483, 1973.
36. Dawson, J. T., Hall, R. J., Hallman, G. L. and Cooley, D. A.: Mortality of Coronary Artery Bypass After Previous Myocardial Infarction. Am. J. Cardiol. 31:128, 1973.
37. Lapin, E. S., Murray, J. A. and Bruce, R. A.: A New Hypothesis to Improve Selection of Patients for Saphenous Vein Graft Surgery. Am. J. Cardiol. 31:144, 1973.

The Impact of Changing Pesticide Usage on the Medical Community

ANNE R. YOBS, M.D.
Chamblee, Georgia

The development and usage of various pesticide products is discussed and the author describes Project Safeguard, an intensive educational program directed to farmers in 14 states including Mississippi. She concluded by emphasizing prevention, populations at risk, signs and symptoms, diagnostic confirmation and treatment of pesticide poisoning.

THE USE OF chemical substances has been increasing steadily in the modern world, filling man's physical environment with a myriad of substances which are potentially toxic to man himself or to parts of his environment. In trace amounts in the human body, some substances have no demonstrable effects, and others are essential to life; in larger amounts, these same substances may be toxic.

Similarly, the number and usage of pesticide products has increased significantly during the last 30 years with the availability of organic chemicals for convenient, effective, and economical pest control in a wide variety of situations. Benefits have included increasing food production and control of disease vectors and nuisance pests. At first, relatively little effort was directed to safe application and controlled use of these chemicals, and knowledge of possible harmful side effects did not keep pace with the development of chemical pesticides. Beginning in the late 1940's, evidence developed that certain chlorinated hydrocarbon compounds, such as DDT, accumulate in fatty tissues of fish, birds, other wildlife, and man. Later studies showed that excessive concentrations of these pesticide residues have adverse effects on reproduction, physiology, and behavior in some birds and represent a threat to wildlife. The hazard to future generations of man is not known, but results of controlled experiments in laboratory animals indicate a need for further investigation.

The general use of DDT in this country was cancelled by the U. S. Environmental Protection Agency effective Dec. 31, 1972, following several years of intensive review and inquiry into the environmental and human health hazards related to the use of this chemical. This administrative action necessitated a change to other available chemicals, such as organophosphates and carbamates, which have been marketed for a number of years. They are more easily broken down in the environment and in biologic systems and therefore pose less risk of long-range contamination and buildup in the environment. However, many of the chemicals which will be substituted for DDT are highly toxic and present greater short-range acute hazard to the user and to others coming into direct contact with them. Since these replacement chemicals are less stable, more frequent application will be required to maintain the same level of pest control, thereby further increasing the hazard—particularly to untrained users.

Project Safeguard, an intensive educational program directed to farmers at risk in 14 states, is a joint effort of the U. S. Environmental Protection Agency, U. S. Department of Agriculture, and the State Cooperative Extension Services. The target states include those Southern and Southeastern states where the greatest use of DDT has occurred in recent years in the treatment of their major crops—cotton, peanuts, and soybeans. A special effort is also being made to alert physicians and emergency health personnel in these states to the potential problem and to review diagnostic and treatment measures with them.

From the Training and Education Branch, Operations Division, Office of Pesticide Programs, U. S. Environmental Protection Agency, Chamblee, Ga.

Everyone engaged in health care delivery should become familiar with all aspects of pesticide poisoning including prevention, populations at risk, signs and symptoms, diagnostic confirmation, and treatment. Review of all pertinent details is not possible within the space allotted, but a few salient points should be emphasized.

Pesticide poisoning is preventable if the user reads and observes all label instructions regarding usage, storage, and disposal. At risk are not only the farmers or applicators, but also their helpers and families.

Pesticides may be absorbed by ingestion, by inhalation, or through the intact skin as a result of negligence, accident, or deliberate action. Absorption of certain organophosphates is at least as effective following dermal exposure as after ingestion. Dermal exposure is of major importance in occupational poisonings, accounting for 77.5 per cent of the cases of occupational poisonings by industrial and agricultural chemicals in California in one year.[1] There is wide variation in the toxicity of individual compounds within a given group of pesticide chemicals such as the organophosphates. Malathion has a low toxicity, while Temik, TEPP, and ethyl parathion have considerably higher toxicity. Both the organophosphates and the carbamates inhibit acetylcholinesterase; organophosphates are permanent inhibitors, carbamates reversible inhibitors. Illness results from accumulation of excess acetylcholine and, while similar, may vary in intensity from compound to compound and group to group. Signs and symptoms include sweating, headache, giddiness, miosis, tearing, increased salivation, excessive respiratory tract secretions, nervousness, blurred vision, weakness, nausea, vomiting, abdominal cramps, diarrhea; subsequent symptoms include chest discomfort, cyanosis, papilledema, muscle twitches, and, in most severe cases, convulsions, coma, and loss of reflexes and sphincter control. Miosis is commonly present, but mydriasis may occur; in either, pupils are nonreactive.[2] If symptoms begin more than six hours after the last known exposure, the illness is probably due to some cause other than pesticides. The end of exposure may be difficult to determine, especially if the patient does not practice good personal hygiene or continues to wear contaminated clothing or protective equipment.

Rapid delivery of correct treatment in suspected cases of pesticide poisoning is of primary importance. Treatment consists of *support, decontamination,* and *specific antidotes* where available. Support therapy includes, most importantly, administering artificial respiration when indicated, while maintaining a free airway. Mechanical means may be used if available; if not, mouth-to-mouth resuscitation should be performed. Oxygen should be administered when cyanosis or severe respiratory difficulty is present. Sedatives may be used with caution to combat hyperexcitability or convulsions; sodium phenobarbital is the drug of choice because of its rapidity of action but should be used with care when there is respiratory impairment. After continuation of respiration has been assured, decontamination of the patient should follow promptly to end exposure to the toxic chemical. Depending on the circumstances of exposure, decontamination may include one or more of the following: removal of contaminated clothing, washing of skin and hair, rinsing of eyes, gastric lavage or induction of vomiting, and eventually evacuation of the intestinal tract.

ANTIDOTES

Specific antidotes are not known for all pesticides, but antidotes of considerable value are available for use in organophosphate poisoning. They are safe enough to administer cautiously on the basis of symptoms before the diagnosis is firmly established. Favorable response to the antidote helps confirm the diagnosis. (Absolute confirmation requires laboratory analysis of proper samples to prove that a sufficient amount of the chemical was in the body at the time of onset of illness.)

Atropine sulfate is a physiological antidote which does not affect the inhibited cholinesterase but blocks the action of acetylcholine on parasympathetic receptors. Atropine sulfate should be administered to adults in doses of 2-4 mg intravenously as soon as cyanosis is overcome and should be repeated every 5-10 minutes until signs of atropinization appear. In all cases where atropine treatment is indicated, a mild degree of atropinization should be maintained for 24 hours and for 48 hours or more in severe cases. Doses for children should be proportional to weight, about 0.05 mg/kg body weight. Patients poisoned by organophosphates show an unusual tolerance to atropine because of the accumulation of excess acetylcholine.

Pralidoxime chloride (2-PAM chloride) (Protopam® Chloride, Ayerst Laboratories) is a specific antidote for poisoning by organophosphates, acting to break the bond between the enzyme and the pesticide metabolite. Treatment is more effective if started early and should always be given in conjunction with atropinization. The dose is

1 g for an adult and 0.25 g for infants, given slowly and preferably by infusion for 15-30 minutes. If infusion is not practical, the dose may be given slowly by I.V. injection as a 5 per cent solution in water for *not less than 2 minutes*. If the first dose produces improvement, it may be repeated after an hour. *2-PAM is contraindicated in suspected carbamate poisoning.*

Patients who require treatment with antidotes should be watched continuously for not less than 24 hours, because serious and sometimes fatal relapse can occur due to continuing absorption or dissipation of the effects of antidotes.

A pamphlet entitled "Diagnosis and Treatment of Poisoning by Pesticides" developed by Project Safeguard discusses pesticide poisoning in more detail and is available in single copies on request to the author. ★★★

4770 Buford Highway (30341)

REFERENCES

1. Kay, K.: Environmental Toxicology in Industry and Agriculture. Arch. Environ. Health. 8:208-211, 1964.
2. Hayes, W. J., Jr.: Clinical Handbook on Economic Poisons. Reprinted October 1971. U. S. Environmental Protection Agency. U. S. Gov. Print. Off., Washington, D. C., 1963.

ACUPUNCTURE?

An attractive blonde was having aches and pains which doctors could not cure. So she sought the help of a local acupuncturist who unknown to her, had a sordid reputation. . . . She was instructed to disrobe completely and the acupuncturist did likewise and started his "therapy." After a few minutes, she asked incredulously, "Are you sure this is acupuncture?"

—*Hawaii Medical Journal*

Internal Medical Audit— A Challenge and Opportunity

TOM H. MITCHELL, M.D.
Vicksburg, Mississippi

The author discusses the background of medical audit and the necessity for hospitals to implement such a program under the new PSRO law. He explains how a program should be set up, describes the program in Vicksburg and stresses the importance of documentation and how continuing medical education can be tied in with such a medical audit program.

FOR SEVERAL YEARS within the various requirements for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals, there has been listed that of medical audit. Since the early 1960's with the introduction of Medicare and then with the advent of Medicaid, this has been a requirement for participation in these particular programs. And then the subject of utilization review was introduced as a supplement to medical audit. In some of our community hospitals the development of an effective approach to meeting this requirement has been hampered by many factors with the resulting programs being weak and more time consuming than productive. During the past two years we have been exposed to increasing emphasis on the national level with the debates in Congress as regards the establishment of Professional Standards Review Organizations (PSROs) and then in the past year the passage of Public Law 92-603. We have this factor introduced now as a legal requirement and the responsibility to develop effective programs within our hospitals and communities rests largely upon the shoulders of the members of the medical staff. This paper is presented with the purpose of discussing the subject and suggesting a means by which it may be handled locally in an effective manner which has the additional advantage of providing an educational experience for the participating physicians.

During recent years all of us have been witness to and participated in many changes in the practice of medicine. These changes deal as much with the interpersonal relationship between patient and doctor as with the basic fundamental practice of medicine. Two terms which have been mentioned frequently throughout this time are (1) quality of care and (2) continuing education. Three factors have particularly contributed to the sudden emphasis on these terms.

First is the fact that from the beginning of medical history physicians have been given the responsibility of policing their ranks and promoting, through education and study, an ever improving quality of practice. In this a fair measure of success has been attained. The patient from his point of view accepted this system without question and looked upon the successful physician as a good physician, making judgment on the individual rather than the profession as a whole. This person-to-person relationship appeared to be working well until recent years. We have seen the expansion of the so-called third party factor from a negligible role to a major role, and we have seen the advent and increasing emphasis placed upon the so-called "consumerism" factor, both of these areas focusing more and more attention first on economic factors involved in the practice of medicine, and now the relationship of quality of care to utilization control as a means of cost control. In other words, quality of care and efficient utilization of the available facilities provide cost control.

Few physicians gave much thought to the overall impact of medical care on the national economy until only lately and the fact that expenditures for medical care equal about 7 per cent of the gross national product in this country comes as a surprise. We physicians have not thought of ourselves as both "providers" and "consumers" in the health care field; but modern economics demonstrates this fact and discloses as well that we are and have been "an unregulated industry" without "cost controls." The physician, not the patient, decides (1) who will be admitted to the hospital; (2) how long he will stay; (3) the tests or procedures that will be carried out; and (4)

Presented before the East Mississippi Medical Society, Meridian, April 3, 1973.

the charge for these services. To restate the emphasis in the preceding paragraph, the services needed by the patient must be provided but must be documented and delivered in the most efficient manner.

Secondly, there has come into existence a body of law based on landmark legal decisions which places the legal responsibility for the quality of care in the laps of the physicians and Hospital Governing Boards. Ultimately, this responsibility rests with the Governing Board because it appoints the Administrator and only it may grant practice privileges to the individual members of the Medical Staff. In order to meet this responsibility, the board must be informed as to the continuing competence of its Medical Staff. For these reasons the Medical Staff has the responsibility to review and determine the competence of its members. Additional emphasis in this area is now in the congressional mill; the requirement of continuing evaluation having been made, the only question remaining is who is to do the evaluation.

The third factor is one most readily accepted by members of the medical profession, but implementation presents a challenge in many ways. A professional by definition is "one who sets performance standards and continually strives to exceed them." Each of us has within us the desire to practice the best medicine possible and the willingness to constantly try to improve ourselves. We are all interested in seeing that good medicine is practiced within our own hospitals and communities. With these thoughts in mind, a review of our performance by our peers to better recognize our strength and those areas that need strengthening can be advantageous to each of us individually, as well as to the hospital and community.

To sum up these three factors, it may be said that the individual physician or hospital can no longer be assumed to be practicing quality medicine but must be able to prove it by documentation, that is, by review of the clinical records, and that the members of the Medical Staff must not only be qualified through basic education but they must demonstrate an awareness of the advances in medical care through their performance in the care of their patients.

From this it may be clearly seen that the entire health care system has been told that it is in the public interest that standards be implemented to provide for quality control in the administration of medical care. To meet this challenge, organized medicine has agreed that the only satisfactory method of quality control rests in peer review; who but a surgeon is qualified to evaluate surgical techniques and postoperative care, or who can evaluate appropriate care of the patient with a myocardial infarction? How is this to be accomplished? The prevailing answer at the moment is the internal medical audit. This has been defined as a "method of continuing medical education based on the evaluation of the quality of medical care as reflected in the medical records."

MEDICAL RECORDS

The last five words, "as reflected in medical records," bear repeating, as from a medicolegal standpoint, it just isn't so unless it is down in black and white, and an order for a medication or a laboratory procedure is not indicated unless reason for same is indicated on the record.

The internal medical audit is to be distinguished from claims review, which is primarily length of stay or cost evaluation, and from external audit, in which individual norms are compared with state or national patterns. It is also separated by a narrow margin from utilization review, which deals primarily with the utilization of the hospital services and/or facilities as relates to the individual patient as well as the resources available within any given community. The point to be emphasized is that this is an internal evaluation of the medical care rendered from which educational needs of the staff may be recognized and met, thereby enhancing the overall quality of care.

Theoretically, in the background there exists medical research from which the physician obtains the necessary medical knowledge by which he makes his diagnosis and develops his plan of management; from this is evolved patient care. The medical audit is in essence a review of the application of this knowledge as expressed in the care given the individual patient and should reflect the current level of education and ability of the individual physician. It centers about the principles mentioned earlier; namely, we all attempt to practice good medicine; we want the best medicine to be practiced in our hospitals; and, if we adhere to these two principles, then we should be willing to submit to personal audit or review.

There is a degree of turmoil within the medical community at present with regard to requirements for continuing education, Board eligibility, and Board certification. The procedure outlined here bypasses this conflict by going straight to the bedside and evaluating the care given to a specific patient. It is felt that if the program is to be successful and truly educational, it must be internal, that clinical topics must be reviewed rather than random charts, but there has to be full participation by the Medical Staff. This may best be carried out on a departmental or sectional basis, unless the size of the Medical Staff does not justify

this. The educational program developed from the audit is two-fold, first, coming from the participation in the audit itself and, secondly, by developing a relevant or practice-oriented educational program from the needs demonstrated in the audit.

To initiate an internal medical audit, there are several steps involved, each of which is an ongoing matter. The first of these deals with the adoption of standards of care. The second step is putting these standards into writing. The third step is to review the care that has been given as put forth in the medical record. The fourth step is that of comparing the care rendered with the standards set, and this is, in essence, medical audit. At the onset, it is necessary that the Medical Staff organize itself either as a single unit, by department, or by section, contingent upon the size of the staff, to officially review quality of care. This done, the disease or conditions to be reviewed must be selected and the development of criteria of optimal care be set by the staff as adapted to local situations, and put into writing.

MISSISSIPPI EMCRO

Approximately three years ago, the Mississippi State Medical Association received a grant to develop an Experimental Medical Care Review Organization as part of a national project, and specifically within our state organization as a part of the peer review mechanism. EMCRO has, at the present time, developed criteria for approximately 70 conditions. These criteria have been developed by specialty panels made up of physicians within our state and form an excellent base or guide, but the final determination so far as criteria, should be on a local basis.

In developing the standards of care or criteria, there are three major sections that one has to look to, those being: (1) the indications for admission, (2) the hospital services provided, and, (3) the length of stay of the individual within the hospital.

In developing the indications for admission, we turn to our own individual activities, for in evaluating a patient and developing a plan of management for the patient, we, on the basis of information gained from the patient's history and our physical examination, decide if the individual should be hospitalized from the time of the first visit. Again, the response to treatment, or the lack thereof, may or may not indicate the need for hospitalization. The criteria utilized in making these decisions for admission represent the indications for admission and should be readily found upon review of the history and physical examination. When speaking of hospital services, one refers to an area covering the utilization of "the hospital" in fulfilling the needs of the patient as spelled out in the indications for admission. It may be quite broad, utilizing the full scope of the hospital, such as laboratory, x-ray, surgery, anesthesia, inhalation therapy, physiotherapy, special diets, etc., or can be quite limited. There may be some required hospital services or procedures which should be carried out, some optional procedures which may or may not be carried out, there are diagnostic procedures which may or may not be indicated, depending upon the individual case. There are certain needs that are indicated in the admitting history and physical examination and others arising during the hospital stay that should be expressed in the progress notes of the clinical record.

Expected length of stay is sometimes a variable factor, but usually fairly predictable, for experience has shown that in uncomplicated cases the recovery rate can be calculated with a fair degree of accuracy, but it is recognized that unforeseen factors can change this quite rapidly. The important factor is that all of the above data is reviewed, discussed, and adapted to local patterns of care and put down in writing.

Having recognized the need and accepted the responsibility of carrying through with the medical audit program, implementation becomes a challenge. Recognizing the need for full participation by the Medical Staff for the program to reach its full potential, it is suggested that a portion of the time set aside for monthly staff meetings every second or third month be used for this purpose. The hospital administration must be looked to for providing personnel to assist in the clerical and record-keeping duties brought about by this program.

In our own institution, we have been using the EMCRO Program for the past year and it has shortened appreciably the time involved of the members of the Medical Staff by reducing the number of records that it is necessary to review. This holds true in both the medical audit and the utilization review areas. The criteria as set forth in EMCRO and as developed by our staff differ very slightly. By using the EMCRO mechanism, all of the records are screened and only those not conforming to the established criteria come up for physician review, which has greatly reduced the work load in this area for the Medical Staff and, consequently, is making a more meaningful program by reducing some of the drudgery involved.

★★★

The Street Clinic (39180)

Partners in Progress—The Private Practitioner and the Public Health Program

PAUL B. BRUMBY, M.D.
Lexington, Mississippi

I ALWAYS remember, as a citizen, that it is our health department that protects both me, personally, and my family from contagion and contamination, from rabies, from dirty cafes, and even poorly run nursing homes. As a doctor, I always say, "our health department," because I realize that the health department was organized and became functional in 1877 by the direct efforts of the Mississippi State Medical Association. Too, I have had the opportunity of watching the development of this phase of our medical care delivery since, as a small boy, I came with my physician mentor to discuss the then forthcoming hookworm drive with Dr. Felix J. Underwood in the Old Capitol Building. This was the drive many, many years ago which would eradicate the cause of our southern indolence, our lack of energy, our lack of industry and enterprise, which the Rockfeller Foundation was going to correct with the eradication of this scourge, the hookworm disease. We Mississippians could not afford and did not wear shoes.

Our part-time health officer came around annually to see that we were vaccinated and inoculated on schedule, and as far as I can remember, he saw that we were properly quarantined with our mumps, our measles and our scarlet fever. The cause or epidemiology of polio had not yet been decided, although, as a child, there were cases on both sides of my family. But, of course, as medical knowledge has increased, there has been a corresponding increase in the scope of the private practitioner as well as the practitioner of public health in their practice of preventive medicine.

We have moved closer together as we realized that the professional preventive medicine specialist can do on a large scale for the public health what we as the physician of the individual have neither the time nor the inclination to do other than to place preventive medicine in a position secondary to our role as deliverer of curative medicine. The health department must be responsible for safeguarding the overall health and welfare and safety of the citizens of my county.

The author discusses the cooperation between the health department and the private physician in protecting the public health. Dr. Brumby, a family practitioner in Holmes County, gives specific details of the experiences in his county in eradication of disease and also providing preventive services to the people. Departments and services of the State Board of Health are described.

Having lived in Holmes County these many years, I have seen our preventive care arm under seige from many sides. Years ago, we felt that many things which a real, live health department officer could or would do encroached on the income-producing practice by state-paid employees. This, of course, was State Medicine. This feeling has long since passed, and every single program now being pursued is supported and aided by our physicians. We have seen Holmes County maligned four or five times on national television, several times on the radio; and only lately in the *Ladies Home Journal,* we see that our county has been adopted by Lyon County, Iowa, because our citizens have neither health nor poverty programs. The first truck of food and clothing has already arrived, and I trust those who came with these blessed gifts can assure their fellows that there are many poverty and health programs and many subsidized low cost housing projects. They can assure their fellow Iowans that there are no old slave quarters, nor are there any people who live in antebellum structures.

Presented before the Section on Preventive Medicine, Mississippi State Medical Association, Biloxi, May 2, 1973.

One endeavor which in the past loomed large with our health officer was health edueation. No PTA meeting or woman's elub was complete without either a health offieer or health nurse to speak or discuss planned health projeets, whether these were mosquito or fly control or preschool examinations. Our health department has been close to our people through all these years. It was certainly a combined effort between our eounty health speeialists and the private praetitioners whieh eradicated smallpox, typhoid, diphtheria and malaria. An intensive county campaign sponsored by the loeal medieal soeiety and the loeal health department eradieated polio and, hopefully, rubella. And, with the urging of the health department, we have for years made every effort to eradicate syphilis. This was a task that I thought complete until only a short while ago.

I have had occasion to investigate the activity of our own health department and one of another Mississippi county. In both of these counties, the number of eitizens reaehed during the past year was astounding. Over 40 per cent of the total population of Holmes County received some serviee from this department and its nurses. There is no wonder that this department gets the cooperation and support of the county offieers and physicians.

PREVENTIVE CARE

As the demand for medieal care has so greatly inereased, the preventive aspeet of medical eare has increased. A desire for quality medical care has become a politieal demand. The old cliché whieh states that more must be spent on prevention than on eure is also becoming a demand. We have seen it stated only recently that the public wants and demands a eomplete program of health and healing of which every individual may have the benefit without undue sacrifice to himself. There are many laws now before Congress which embody this idea. There are before Congress all types of plans and schemes, but we cannot embraee the World Health Organization definition which states that "health is a state of complete physical, mental and social wellbeing, and not merely the absenee of disease or infirmity." The HMOs which recently were so strongly advocated by our President were predieated on the idea that they could decrease both hospital and medical bills because of their so-ealled emphasis on preventive care. After studies of large prepaid capitation groups, this is being emphasized although questioned. And, we all give great thought and study to all types of medieal care delivery systems.

There are but a few days in which local health nurses and we physicians do not discuss some phase of our local health care delivery. There are many programs of which we as physicians are proud. Our prevention of communicable diseases seemed to have reached the stage of simply preventing recurrences of our old enemies. Our problem with VD has caused an all-out, hopefully effective, VD Control Project. Again, both the health department and the private sector are working in elose eooperation and routine VDRLs are again being done. Several years ago, we discarded this offiee testing after having found no positive serologies for over two years. In fact, in routine prenatal serology we had found no positive in 17 years in our prenatal patients until only recently. And, the advent of our nurse midwives directed from our University Medical Center has certainly been a joint endeavor of our health department, the University group and the local physician.

CARE DELIVERY TRENDS

There are definite needs and trends in medical eare delivery even in our health department. Certainly, hypertension which affects some 40 per cent of our over-60 population causes many CVA problems. And, certainly to eontrol hypertension would be a measure of preventive medicine. This responsibility, of eourse, is a publie health responsibility and the responsibility of the private physieian. Family planning is the newest endeavor to be incorporated into the responsibilities of our health department. And, in the areas of hypertension and family planning, our health department is doing an excellent job at present. There are now 935 women enrolled in the family planning program. In our eounty, the health department has had prenatal elinics in four or five locations and any abnormality was referred to a local physieian. Hospital care was available for those who aetually needed it. These patients were given good prenatal eare; and, if there were needs appraised even among the babies of these patients, these needs were met.

It is true that the County Health Improvement Program (CHIP) with many nurses, midwives, aides, health educators, home visitors and nutritionists with assigned motor vehieles has eaused a decrease in infant and maternal mortality; however, this is true statewide. Their program outreach has brought many young pregnant women into their health clinies. In fact, these young women are the envy of their neighborhood. They receive free prenatal and hospital care, eonstant

home visiting, supplemental diet and visits by clinical nutritionists. Of course, as soon as the baby is born, it will be placed on welfare and will be given aid to dependent children; the percentage of illegitimacy is overwhelming. Of the last 182 deliveries through the program, 101 have been illegitimate. The baby is entitled to dependency status and its mother by judicial decree; so once on ADC this is for them a future way of life. It is true that our county has experienced almost a 15 point drop in the fetal mortality per 1,000 live births, but the four very premature babies who were saved at our premature center almost completely accounts for this drop in the county with 508 live births. We certainly follow the idea that the individual welfare of a person in most instances is the responsibility of the individual physician, whereas our health department has for its responsibility the health and welfare of the community. This is being ever broadened. We are happy to see a close check on our hypertensives and in our chronic disease clinics a close check on our diabetics. And, certainly the project of administering INAH to positive TB reactors is a great good for the county welfare as well as for the individual. We remember each day that the natural history of tuberculosis has gradually changed over the past 30 years, but in 1972 there were 547 new cases. Whether we accept the present concept that health care is a right, or that the access to health care is a right, the future holds for our preventive arm just what it holds for me—a widening of our endeavor to become more determined to offer and to give to the fullest all that either curative or preventive medicine has to offer.

STATE BOARD OF HEALTH

I would like to discuss the structure of the Mississippi State Board of Health as it is today. There are eight physicians, each appointed by the Governor for staggered terms of six years. In addition, a Governor-appointed pharmacist, an optometrist, and a dentist participate in all activities of the board except medical licensure. The twelfth member by law is selected by the other 11 members to be the Executive Officer. The law states he "must be well versed in hygiene, sanitary sciences, and otherwise fitted and equipped to execute the duties encumbent upon him by law." He is elected by the other 11 members within the above guidelines.

There are many divisions within the health department of which you are familiar. These programs are the ones to which we are all committed. I cannot adequately thank these divisions for the many favors they have done for me—for getting to the Alabama Gretna Green the beautiful daughter of our leading citizen with a hurried VDRL or for the examination of a dog's head for rabies by our laboratory out of hours. I am grateful to each of them, and every physician is indebted to the State Board of Health Public Health Laboratory. There is a Nursing Home Division for supervision and licensure of nursing homes. There is a Health Facilities Unit which certifies hospitals and home health agencies for Medicaid and Medicare participation. The Vital Records Department furnishes birth and death records. There is a Merit System for statewide employment. The Statistical Service keeps us up to date on mortality and morbidity. There is a Radiological Service using authority delegated by the Atomic Energy Commission. There is an Occupational Health Division aiding industry in providing safer working conditions, an Emergency Health Unit for disaster planning, a Communicable Disease Control Division, a General Health Services Division which includes Crippled Children and Cystic Fibrosis Control; there is a Heart Disease and Cancer Control Unit; there is a Mental Health Division which was considered by the Legislature for transfer and is now in the hands of the politicians. Home Health Services have been added to provide skilled nursing for homebound patients. The Family Planning Division added in 1971 is designed to work with an advisory committee composed predominantly of consumers. An in depth study asks what other preventive health measures need to be effectively utilized.

One singular encounter with our health department is well remembered by all of us. That, of course, is our examination and licensure by the State Board of Health. The state charges the board with certain specific duties. The board must be sure that you have both the education and training to render expert services to the public and it demands certain conduct and prescribes certain conditions. There are certain operations and certain drugs which are prohibited to you and the state, through the board, reserves the right to change or to alter its rules and restrictions. One board member complains that the removal of a narcotic license from a physician is hard, but to revoke the license of a physician in practice is the hardest thing that the board must do. And, we must remember, above all, that the possible demand for proof of postgraduate education for relicensure is sure to come.

We remember with no pleasure our struggle in college to make grades to get into medical school, and in medical school that we might graduate, at

which time we knew our chances to pass our State Board were almost automatic. This is not true this year, and I have seen tears in the eyes of our seniors because they must encounter the almost nationwide FLEX examination which is routine in most of our states, but is new here. One day of the three-day examination consists of a written test on basic scientific subjects. The second day there is a written test which includes the clinical studies with a value of one-third of the examination. And, the third is an oral comprehensive to have a value of one-half of the examination. Licensure then will be nationwide. One additional fact I would like to mention, and I would like your studied answer to be given to your legislative representative.

In 1970, Peat, Marwick and Mitchell reported their recommendations for reorganizing many state agencies, including the State Board of Health. If adopted, this recommendation would have restructured the board governing the health department, providing for appointment of only one physician who would have an equal voice with that of a nursing home administrator and many other laymen. Another board made up of physicians would handle medical licensure only. This recommendation MSMA has vigorously resisted because it strips the medical guidance from the board governing the health department.

The current Legislature has considered a committee to study the restructure of our state health department. We certainly ask again, "shall there be nonprofessional, unskilled and undedicated consumers controlling the destiny of our state health department or should control be left in the hands of professional health providers?" Think of this and give your decision to your elective political representative. ★★★

102 Carrollton Street (39095)

SEVEN DEADLY SINS

The Seven Deadly Sins are: 1. Politics without principle. 2. Wealth without work. 3. Pleasure without conscience. 4. Knowledge without character. 5. Business without morality. 6. Science without humanity. 7. Worship without sacrifice.

—E. Stanley Jones

EIGHTY-FIFTH ANNUAL MEETING of the MID-SOUTH MEDICAL ASSOCIATION

(Formerly Mid-South Postgraduate Medical Assembly)

FEBRUARY 13, 14, 15, 1974
at the
SHERATON-PEABODY HOTEL
MEMPHIS, TENNESSEE

Outstanding speakers will present half-hour lectures on subjects of interest to both general practitioners and specialists. A well-balanced program is scheduled. Make your plans to attend!!

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MAKE YOUR PLANS NOW TO ATTEND THE MID-SOUTH MEDICAL ASSOCIATION MEETING

FEBUARY 13, 14, 15, 1974

MEMPHIS, TENNESSEE

Radiologic Seminar CXXXV: Bipartite Patella

OTTIS G. BALL, M.D.
Jackson, Mississippi

THE PATELLA develops from one or more ossification centers which appear between the third and fifth years of age. These gradually enlarge and fuse with ossification completed about the age of puberty. When these centers fail to fuse, a bipartite, tripartite, or multipartite patella results (see Figures 1 and 3). The bipartite patella is usually an incidental finding and of no clinical significance. However, there have been case reports in which a painful knee has been attributed to the presence of a bipartite patella.

Practical importance of the radiographic demonstration of a bipartite patella concerns the recognition of this minor congenital anomaly as distinct from pathological abnormalities of the patella. The most common clinical situation would be in regard to knee injury in which a fracture of the patella is suspected.

The features which distinguish a bipartite patel-

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital, Jackson, Miss.

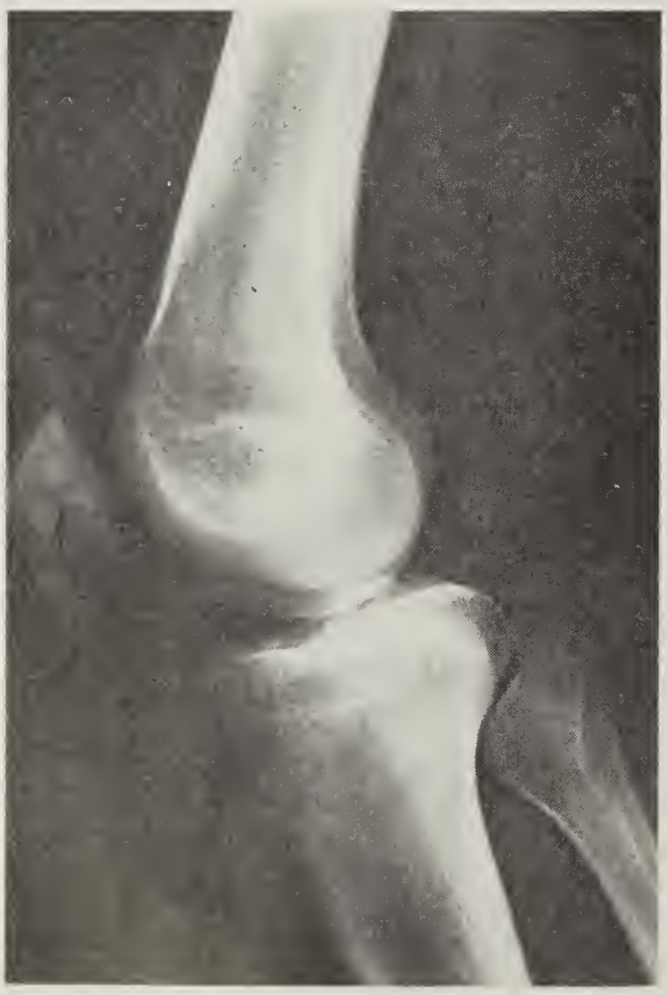


Figure 1A

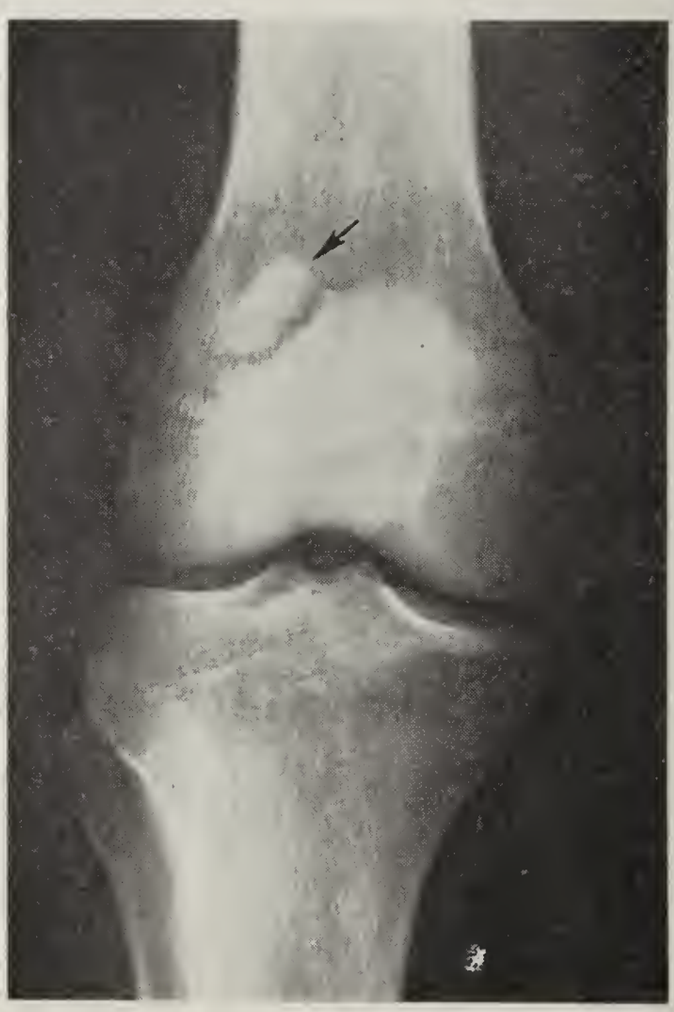


Figure 1B

Figure 1. Bipartite Patella. Note smaller bone in the upper outer quadrant (A) with the relatively smooth, undulating margin along the cartilage line. (B) Compare with Figure 2.



Figure 2A



Figure 2B

Figure 2. Fractured Patella. Note small fracture fragment at inferior margin of patella with serrated margin along the transverse fracture line (A and B). The fracture is non-visualized on the skyline view, but soft tissue swelling is apparent (C).

la from a fracture include: (1) the bipartite patella is frequently bilateral, (2) usually consists of a main large bone and a small bone usually situated at the upper outer quadrant of the patella, (3) the radiolucent line of demarcation between the bony parts runs downward and lateral, (4) the opposing margins are smooth, dense, and can be seen to be composed of bony cortices.

Other less common conditions to differentiate would be osteochondritis dissecans and bony ossicle formation secondary to chronic dislocation of the patella.

Skyline, PA, and oblique views in addition to the standard AP and lateral views may be very helpful in better demonstrating this condition. Of course, films of the opposite knee are also helpful. ★★★

1151 North State Street (39201)

REFERENCES

1. Caffey, John: Pediatric X-ray Diagnosis. 5th Ed., 764-767, 1967.
2. Davis, M. B.: Stress Fractures of the Patella. J. Bone & Joint Surg. 42B:71-74, 1969.

(See page 20 for Figures 3A and 3B.)



Figure 2C



Figure 3A

3. McDougall, A. and Brown, J. Douglas: Radiological Sign of Recurrent Dislocation of the Patella. J. Bone & Joint Surg. 50B:841-43, 1968.
4. Turek, Samuel L.: Orthopaedics, Principles and Their Application. 2nd Ed., 159-160, 1966.



Figure 3B

Figure 3. Tripartite Patella. Note two smaller bones in the upper outer quadrant demonstrated on the AP (A) and skyline views (B). Also note healing fracture of the lateral tibial condyle.

An unfortunate fellow got run over by a steam roller. He's in the hospital now—rooms 23, 24, 25, 26.

Mississippi State Medical Association Statement on Abortion

This statement is not intended as an expression of policy to the physician or his patient on the issue of abortion. Rather, it should be considered only as a discussion of the status of abortion at present from both the legal and medical perspective in Mississippi and as a guide to physicians in this regard.

LEGAL CONSIDERATIONS

On Jan. 22, 1973, the United States Supreme Court rendered two landmark abortion rulings in *Roe vs. Wade* and *Doe vs. Bolton,* which declared the abortion laws of Texas and Georgia, respectively, unconstitutional. The court, in its opinion, indicated the maximum extent to which the state can regulate abortion, thus leaving the states without effective abortion laws. Three major limitations on state regulations were set:

1. *First Trimester of Pregnancy*—abortion must be left to the medical judgment of the pregnant woman's physician.

2. *Second Trimester of Pregnancy*—a state may regulate abortion procedures in ways that are reasonably related to maternal health.

3. *Third Trimester of Pregnancy*—a state may regulate abortion (except where it is necessary to preserve the life or health of the mother) because the fetus is potentially capable of life outside the womb.

In any consideration of both these cases it is important to point out the court's admonition to the effect that *a pregnant woman does not have an absolute constitutional right to an abortion on her demand.*

Prior to the *Roe* and *Doe* decisions, Mississippi law had permitted abortions only where necessary for the preservation of the mother's life or where the pregnancy was caused by rape. In light of the U. S. Supreme Court's ruling on abortion, the Mississippi Supreme Court heard a challenge to our abortion statute in May 1973 in the case of *Spears vs. State of Mississippi.* As a result of the *Spears* decision, the Mississippi abortion law was held to be constitutional with the exception of that portion of the statute which permitted an abortion only where it was necessary to preserve the mother's life or when the pregnancy resulted from rape. It is worth noting that the Mississippi Supreme Court, like the U. S. Supreme Court, also held that a pregnant woman does not have an absolute constitutional right to an abortion on her demand.

With respect to any restrictions placed on abortion after the first trimester by the state, our supreme court held that that was a matter for the Legislature to decide based on recognized state interests as set forth by the *Roe* decision in the following language:

"The decision leaves the state free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are tailored to the recognized state interests. The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available."

POSITION OF THE ASSOCIATION'S HOUSE OF DELEGATES

As stated previously, prior to the *Spears* decision Mississippi law permitted an abortion only where it was necessary to preserve the life of the mother or when the pregnancy results from rape.

In May 1970, the association's House of Dele-

gates adopted the resolution set forth below, which, in effect sought to expand the then existing law to provide for abortions on the grounds of therapeutic indications, fetal considerations and when the pregnancy results from either rape or incest:

WHEREAS, Mississippi law prohibits abortion except where continuation of the pregnancy poses a threat to the life of the patient or where the pregnancy results from forcible or statutory rape, and

WHEREAS, A significant number of states have recognized that abortion may be lawfully performed when one of the foregoing conditions prevails or when the pregnancy results from incest, when continuation of the pregnancy poses a threat to the health of the patient, and/or when, in cognizant medical opinion, there is a probability that the infant will be born deformed, and

WHEREAS, The American Medical Association and the American College of Obstetricians and Gynecologists have respectively approved abortion under any one of the foregoing conditions, and

WHEREAS, There is strong opinion among citizens of the state and the medical profession that the Mississippi law should be amended to reflect these additional socially and medically acceptable conditions under which this procedure may be performed, now, therefore, be it

Resolved, That the policy of the Mississippi State Medical Association be that abortion should not be performed except when (1) the pregnancy results from forcible or statutory rape or from incest, (2) continuation of the pregnancy poses a threat to the life or health of the patient, or (3) when, in cognizant medical opinion, there is a probability that the infant will be born deformed; and that the procedure be undertaken by a physician only (1) when consultation has been obtained in writing from another physician and (2) the procedure is performed in a licensed hospital, and be it further

Resolved, That this policy in no way alters the association's long-standing view that criminal or illicit abortion be vigorously prosecuted under applicable criminal law, and be it further

Resolved, That amendments in existing Mississippi law be sought to implement this policy during the 1971 Regular Session of the Mississippi Legislature.

Pursuant to adoption of the foregoing resolution by the 1970 House of Delegates an unsuccessful effort was made to have the 1971 Regular Session of the Legislature amend the laws to permit abortion where the health of the mother is threatened, where there is a probability that the infant will be born deformed, or when the pregnancy results from incest.

Since that time the House of Delegates has not acted on the issue of abortion.

STATEMENT BY THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

As a result of the *Roe* and *Doe* decisions, the Executive Committee of the American College of Obstetricians and Gynecologists, on Feb. 10, 1973, issued the following statement concerning abortion:

Abortion is a surgical procedure. For its performance, adequate facilities, equipment and personnel are required to assure the highest standards of patient care.

First trimester abortions (up to 12 weeks gestational age) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by a state or province.

Abortions beyond the first trimester should be performed in a hospital.

Facilities for the performance of first trimester abortions should include the appropriate surgical, anesthetic and resuscitation equipment. In addition, the following should be provided:

1. Verification of the diagnosis and duration of pregnancy.
2. Pre-operative instructions and counselling.
3. Recorded pre-operative history and physical examination, particularly directed to identification of pre-existing or concurrent illnesses or drug sensitivities that may have a bearing on the operative procedures or the anesthesia.
4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.
5. Prevention of Rh sensitization.
6. A receiving facility where the patient may be prepared and receive necessary pre-operative medication and observation prior to the procedure.
7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia and can be safely discharged by the physician.
8. Post-operative instruction and arrangements

for follow-up including family planning advice.

9. Adequate permanent records.

It is recognized that abortion may be performed at a patient's request or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept an abortion.

The usual informed consent, including operative permit, should be obtained. The same indications for consultation should apply to abortions as to other medical-surgical procedures.

Abortion should be performed only by physicians who are qualified to identify and manage those complications that may arise from the procedure.

It is important that the provision of abortion services does not interfere with the care of other obstetric-gynecologic patients or with residency training programs in obstetrics and gynecology. Consideration should be given by hospitals to providing facilities where abortions can be performed with minimal disruption of other hospital functions.

This statement has since been adopted by the Mississippi Chapter of the American College of Obstetricians and Gynecologists, and the Board of Trustees of the MSMA.

JAMES O. GILMORE, M.D., Chairman
MSMA Board of Trustees

The advertising in the JOURNAL MSMA helps pay the publishing costs! This month the JOURNAL is pleased to acknowledge five new in-state ads. Please patronize local and national advertisers and when you have an opportunity, tell them you saw their company's ad in your journal.



The President Speaking

"The AMA and PSRO"

ARTHUR A. DERRICK, JR., M.D.
Durant, Mississippi

IT WAS OUR privilege to attend the AMA Clinical Convention in Anaheim. For a while I thought the choice of a meeting site adjacent to Disneyland most appropriate.

When the Reference Committee hearing on AMA PSRO policy came up, and I, along with over 500 others, listened to the heated and often emotional discussion of the 10 resolutions offered, I wondered if we were in "Fantasyland" or even "Tomorrowland." Some of it was indeed fantastic. After four hours, during which no speaker's time was limited, except, as the report states, "by fatigue," cooler heads began to prevail and a recess was declared, during which the authors of the resolutions from California, Illinois, Michigan, Kentucky, Louisiana and New York delegations conferred and came up with a compromise amendment which was accepted unanimously by the House of Delegates, proving once again the effectiveness of frank discussion with verbal catharsis to clear the air so that calm deliberation may follow.

I received eminent satisfaction from this demonstration, for our profession was threatened by a most divisive issue, and divided we do not need to be!

The AMA policy on Professional Standards Review Organizations is as follows:

The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

3. That the association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our longstanding policy and opposition to this legislation prior to passage. ★★★

JOURNAL OF THE
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EDITORIALS

CHP: A Three-Letter Word and a Medical Imperative

Comprehensive health planning, something which has been around since its enactment by the Congress in 1966, is maturing from an unremarkable adolescence into a rather hefty—if not athletic—adult. No less than three presidents of the state medical association have addressed themselves to the subject, and it's time that the practicing physician gets into the act.

To begin, the 1966 and 1967 CHP enactments merely empower the Surgeon General of the U. S. Public Health Service to give technical and financial assistance to states desiring to marshal their resources for better health services. If they do not wish to avail themselves of the program, they may simply ignore it.

But if they do choose to ignore the opportunity, then they simultaneously surrender some local prerogatives. To initiate CHP, a state must not only act affirmatively but it must also apply to do so. Each of the 50 states, the District of Columbia, and the five territories (Puerto Rico, Canal Zone, Virgin Islands, Guam, and American Samoa) are in the program.

CHP is organized at state level with the state running the show. At substate level, there are area-wide health planning councils with wide latitudes in organizational opportunities. These may be a municipality, county, combination of counties, and they may be in one or more states. The only limitation is that the areawide council may not be an entire state. These are 314(b) organizations, while the state is the 314(a) organization.

The state CHP is almost invaribly an arm of government. In Mississippi, ours is an extension of the Governor's office. But the law even permits this single state agency to be a private corporation.

The area council may be governmental or private. In Mississippi, our three recognized and funded councils are private, nonprofit corporations.

And there's little chance of bureaucracy, either, for the volunteer participants who run the organizations outnumber government officials and employees by a hundred to one.

For some, health planning means magic, a sort of yellow brick road to a medical never-never land where no human need is unmet.

To others, it is a dark and menacing conspiracy threatening our liberties and inalienable rights.

The facts make it clear that health planning is neither magic nor conspiracy. Since there is no warranty upon the success of planning results, it certainly isn't magic. Not only may we bungle translation of the plan into reality, but the plan itself may be tragically deficient.

And since the chosen plan neither dictates nor requires anything other than a suggested course of action, it can hardly be viewed as a dark and threatening conspiracy.

The premise of the program is simple: The only reason that we must plan is because our aspirations are greater than our resources. When we want, or even need, more than we have or can get, then we must make assessments and consider choices or alternatives. We must also assign priorities to reach objectives in the quest for broad goals.

Most CHP members are consumers of health care, and this isn't all bad, either. Consumers,

after all, may be bankers, educators, governmental leaders at local level, businessmen, professionals in nonhealth fields, as well as housewives, the clergy and rabbinate, and a whole cross-section of the community. We are finding out that this works quite well, and the health care team is thereby enabled to broaden its base of support.

The same law giving us PSRO also gives us added clout in local level comprehensive health planning. Every nickel of federal grant money is screened by the area council and state CHP. Neither can guarantee delivery and project approval, but it's 20-to-1 they can wipe a project out.

CHP organizations exercise the life and death function of approving federal certificates of need, now required for capital expenditures for medical facilities (1) exceeding $100,000, (2) substantially altering the scope and extent of services, at whatever cost, or (3) altering the number—up or down—of beds. This applies to hospitals, nursing homes, HMOs, home health agencies, and every facility. The physician is, of course, exempt.

Now, the law can't stop such expenditures or projects to expand or change services, but it can stop payment under three federal titles: Maternal and Child Care (V), Medicare (XVIII), and Medicaid (XIX).

What is of paramount importance is that local physicians and health care team members, in concert with their own neighbor-consumers, are making these decisions. If this has come to pass in the present health delivery and financing climate, then how much more important will it be when (not "if") we have some form of national health insurance?

Your editor speaks from experience as an active participant in the Central Mississippi Health Planning Council, wading through certificate of need applications and grant protocols (some with merit and some which are high class science fiction). He has cast a vote, and he serves as a nominee of his component medical society, responsible for his actions to his peers.

This brings along the peroration, because CHP, as with anything else flexing new and growing muscles and clout, has its *caveats:*

—Physicians must and should serve at all levels of organization in comprehensive health planning. If we are on the outside looking in, we can only throw stones.

—Physicians who do serve should be chosen by their component medical societies, underpinning their representation with the will and wishes of the medical society.

—Medical policy must be medically determined in CHP as well as anywhere else.

—Medical organization has a duty and responsibility to send the MDs who can and will patiently educate and illuminate muddy situations and circumstances where lack of medical leadership means medical fiasco.

—Medical organization, in its highest councils and governing bodies, ought—indeed, must—be concerned with comprehensive health planning. It can make a priceless contribution in what may well be one of the most influential vehicles in the health services delivery future.

Each of the 10 area CHP councils in the state, the three operational bodies and seven emerging groups, are asking for M.D. support, medical society participation, and medical leadership. If we fail them, we may have failed ourselves and our patients.

W. Moncure Dabney, M.D., Editor
Crystal Springs, Miss.

Don't Call It UCR

Any resemblance to Medicare's payments to physicians and usual customary and reasonable fees of physicians, if it ever existed, is now purely coincidental.

As the association's Council on Medical Service noted in an article in the *Journal MSMA* last month on "Medicare/Medicaid Amendments," what started out as payment of a "reasonable charge" for physicians' services in "Medicare 1966" has been progressively modified by the Bureau of Health Insurance Directives and currently by Cost of Living Council Guidelines.

The general definition of "usual customary and reasonable charges" as found in most major medical contracts offered by insurance carriers and as adopted by the American Medical Association is as follows: "Usual" is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee); "customary" is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area; "reasonable" is defined as a fee which meets the preceding criteria or is justifiable in the special circumstances of the particular case in question.

A physician's "customary charge" for Medicare purposes, beginning July 1, 1974, will be that dollar amount which would cover his fee for a

procedure in at least half the instances that procedure was performed during 1973.

The "prevailing charge," which sets the ceiling on reimbursement for physicians services in a Medicare fee area, is that dollar amount which would cover the charge for a given procedure 75 per cent of the times it was performed during the year if each physician actually charged, in each instance, his Medicare calculated "customary charge." Under this criteria the maximum authorized fee for a procedure is the lesser of (a) the 50th percentile of the physician's fees for the procedure or (b) the 75th percentile of the fees for the procedure charged by all physicians in the area.

A "reasonable charge" under Medicare is then defined as a charge which meets the above criteria—but wait a minute! Cost of Living Council regulations further restrict Medicare allowances by defining the Medicare "reasonable charge" screen as a "price list" and applying to the screen itself the present 2.5 per cent limitation on increases in physicians' charges. Therefore, Medicare can recognize only a portion of the annual increase in prevailing charge levels that would take place even under Medicare "customary, prevailing and reasonable charge" regulations.

Medicare, you can call it a lot of things but don't call it UCR.

CHARLES L. MATHEWS
Executive Secretary, MSMA

American Hospital Association Quality Assurance Program—QAP

The AMA has formally adopted a study and report of its Council on Medical Service and Committee on Private Practice on the American Hospital Association Quality Assurance Program—QAP. A number of Mississippi hospitals are considering implementing the QAP program. The report set forth certain concerns about the operation of the program. The primary concern was that the program had a potential for lay control of medical practice. In the light of these concerns the report refused endorsement of the program; but it offered a series of suggestions to hospital medical staffs and governing boards considering implementation of QAP:

1. Participation by governing board members on the main Quality Assurance Program Committee should be considered as a means for improving communications between the governing board and the medical staff in the same fashion as medical staff representation on the governing board and its action committees.

2. Participation by representatives of hospital administration as well as other allied health professions, consumers, and patients in the Quality Assurance Program structure should be at the invitation of the medical staff and such representation should only be in an advisory or supportive capacity.

Such participation could lead to a cooperative interrelationship among the various elements of the hospital concerned with patient care, could lead to improved communications, and would emphasize the authority and accountability of the medical staff for the operation of the program.

3. The Chief Executive Officer of the hospital should be invited to attend all meetings of the Executive Committee of the medical staff, to which the QAP committee reports.

4. The medical staff should have direct access to the governing body, so that the results of its findings, as these regard the administrative operation of the hospital and its impact upon the lengths of stay, provision of ancillary services and quality of care, may be made known to the governing board.

5. The chairman of all committees concerned with the Quality Assurance Program should be appointed by the elected officers of the medical staff.

6. Personnel working with the medical staff committees in carrying out assigned functions; i.e., nurse coordinators and health record analysts, should be directly responsible to the respective committee. Liaison with hospital administration that is required in the operation of the program should be a responsibility of the committee chairman, who may delegate certain day-to-day liaison



functions to the coordinator.

Finally, because of the unproved nature of the Quality Assurance Program, the report called for making the following suggestions to the American Hospital Association:

1. The Quality Assurance Program should first be tested in a limited number of hospitals so that its operation may be studied and evaluated.

2. Tests should be conducted in some hospitals in conjunction with PSRO-type operations, so that the interrelationships of the two approaches may be studied.

3. Local medical societies should be involved in the evaluation of the effectiveness of the QAP program.

"Contraceptive Technology" Published

The sixth edition of "Contraceptive Technology" was published this fall by the Emory University Family Planning Program, Department of Gynecology and Obstetrics, School of Medicine.

Fifty thousand copies of the concise 56-page manual are being printed including 3,500 sent to the Agency for International Development in Washington, D. C. for international distribution.

Ten thousand copies will go to the national Planned Parenthood headquarters in New York City, and another 10,000 will be sold to medical schools and health organizations throughout the country, according to Dr. Robert A. Hatcher, director, Emory University Family Planning Program.

Medico-Legal Briefs

THE SUPREME COURT AND ABORTION: REJOINDERS

As soon as the decisions of the U. S. Supreme Court on the abortion question were handed down, one could be certain that articles about them would appear in legal, medical, and lay journals and magazines.

Already one such article has appeared in *Modern Medicine* (Alan A. Stone, M.D., "Abortion and the Supreme Court." *Modern Medicine,* Apr. 30, 1973, pp. 32-37). And an exhaustive critique has been published in the *Fordham Law Review* (Robert M. Byrn, "An American Tragedy: The Supreme Court on Abortion," 41 Fordham Law Review 807, 1973).

Dr. Stone is professor of law and psychiatry in the faculty of law and the faculty of medicine at Harvard University. He describes himself as "an early champion of the right to abortion." Mr. Byrn is professor of law at Fordham University School of Law. He is noted for his anti-abortion stance. Both take issue with the Supreme Court's 1973 decisions in *Roe v. Wade* and *Doe v. Bolton,* 93 S.Ct. 705 and 93 S.Ct. 739, respectively.

Professor Byrn can be accused of overkill. He provides arguments and citations almost without limit to show why he believes the court erred in reaching its decision. Dr. Stone, with more objectivity, points out that the decisions were read by many with disbelief that this "strict constructionist court could author such an exercise in ipse dixit." Both articles are substantial, albeit different, contributions to the literature. They are important to our understanding of *Doe v. Bolton* and *Roe v. Wade* and their effect.

Professor Byrn discussed "historical errors" in great detail. His review of English common law on abortion is impressive. His review of American law is equally impressive. It is interesting, too, as it tends to show the development of the law as the mysteries of science unfold. Then he discusses the relation of the issues raised in the cases to the 14th Amendment. All this leads to a philosophical yet practical discussion of what Professor Byrn calls "errors on the question of human life and human-legal personhood." His article reaches its zenith at this point, as he discusses what he calls the "social engineering overtones" of the decisions, especially the language used in *Wade.*

The "social engineering overtones" suggest to him that the court opens the door to solving quality-of-life problems by compulsory abortion and involuntary euthanasia. He writes: "Given a carefully orchestrated controversy . . . and the Court's unwillingness in *Wade* to recognize the fact of life unless there is a 'consensus' on its value, a state might persuasively claim that it is free to remove a live human being (e.g. a senile elderly person) from the law's protection."

Dr. Stone, in a completely different way, questions the soundness of the court's approach to its conclusion. He does not find himself in disagreement with the conclusion; rather, he is mystified by the way Justice Blackmun arrived at it.

Dr. Stone agrees that Justice Blackmun is correct in concluding that to the extent the state wishes to protect the health of the mother it should regulate abortion like any other medical

procedure. Continuing, the doctor points out that the other basis for the state's interest is the protection of prenatal life. It is this question, he says "that reaches all of the moral, ethical and religious values." He suggests that Justice Blackmun avoided any deep analysis of moral sensibilities and gave short shrift to history and ethical tradition. Of the Justice's review of the Oath of Hippocrates he writes: "Obviously, Justice Blackmun implies that to understand is to dismiss."

Dr. Stone adds that the court, having sidestepped consideration of "the different question of when life begins" goes on (by providing that the state can proscribe abortion only in the third trimester and then only to protect the life or health of the woman) to place the health of the mother above the "visible" life of the child. Dr. Stone writes that "this is a strange moral calculus; it obscures the line between feticide and infanticide, and it suggests the court's failure to come to grips with the fundamental questions it raised."

The decisions, according to Dr. Stone, put impractical, if not impossible, burdens on the medical profession. Medical regulation of abortion must be hierarchial, he says; yet this is scarcely "legal" under the decisions. Consequently, though necessarily, "medical regulation" could become no more than "the power of persuasion and the sanction of social ostracism."

More profound an effect of the decisions in Dr. Stone's view, is the distinct possibility that many women may be forced to have abortions, not because of their *right* to have them, but because they are forced by egocentric men to submit to the procedure to avoid an unwanted inconvenience to men. To the extent this happens —and it has happened in other countries, he asserts—neither the dignity of life nor the dignity of women will be enhanced.

Each article is essentially pessimistic. Each suggests that serious undesirable results are the to-be-expected end product of the decisions. One author holds to his thesis because of his conviction that the decisions are wrong. The other believes the decisions, although correct, are poorly reasoned and poorly drafted; that they are too sweeping; too casual; and too imprecise to achieve what he believes would be the desirable result. Neither is satisfied with the decisions.

Both articles exude sincerity and concern. Both demonstrate a thoughtful approach to a matter of serious concern. Both are examples of outstanding craftmanship. Both are better expressed and reasoned than the decisions under review. Both are a contribution to the literature. Both are commended to all who are interested in the relationship between man and his fellow man in the institution for their benefit called "the state." —Edwin J. Holman, LL.B., Director of AMA Department of Medical Ethics.

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POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Jan. 7-11, 1974

ELECTROCARDIOGRAPHY INTENSIVE COURSE

University Medical Center, Jackson

Jan. 7-11, 1974, beginning at 9:00 a.m.

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Thomas M. Blake, M.D., professor of medicine, The University of Mississippi School of Medicine

Selected for their immediate applicability, topics in this one-week course will be supplemented by use of electrocardiograms, slides and other visual aids. Participants will interpret electrocardiograms and join in conferences.

Jan. 14-18, 1974, and Feb. 4-8, 1974

NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

University Medical Center, Jackson

Jan. 14-18, 1974, and Feb. 4-8, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Alfred W. Brann, Jr., M.D., assistant professor of pediatrics and director, newborn center, The University of Mississippi School of Medicine

This course, presented in January and repeated in February, is planned for physician/nurse teams. Most of the content will be presented in joint sessions, with ample time allowed for discussion of special problems in nurseries represented by the teams in attendance. It is open to physicians involved in the care of newborns as the primary physician. There is a $10.00 fee for physicians.

Feb. 4-8, 1974

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Feb. 4-8, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

W. Lamar Weems, M.D., associate professor of surgery (urology), The University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

Feb. 11-15, 1974

PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson

Feb. 11-15, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinators:

J. M. Montalvo, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Nell J. Ryan, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Registrants will participate in intake and ward rounds and refresh their skills in such areas as scalp vein techniques, use of the respirator, resuscitator, nebulizer and humidifier. Lectures and round table discussions will take up common pediatric problems such as immunizations, allergies, pediatric emergencies, pediatric surgery and care of the newborn.

Feb. 18-22, 1974

OTOLARYNGOLOGY INTENSIVE COURSE

University Medical Center, Jackson

Feb. 18-22, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Godfrey E. Arnold, M.D., professor of surgery (otolaryngology) and director of the Division of Otolaryngolory, The University of Mississippi School of Medicine

At least 30 per cent of family medicine is concerned with ear, nose, and throat diseases. This course will present the basic knowledge of otolaryngology as needed by the family physician, including office treatment and detection of complications. Lectures, seminars, clinics, rounds, demonstrations and surgical observations will take up audiology, vestibular testing, speech and voice rehabilitation, allergy clinics, and neurotology.

All the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research

Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

FUTURE CALENDAR

Jan. 7-11, 1974
ELECTROCARDIOGRAPHY INTENSIVE COURSE

Jan. 14-18
NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

Feb. 4-8
UROLOGY INTENSIVE COURSE

Feb. 4-8
NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

Feb. 11-15
PEDIATRICS INTENSIVE COURSE

Feb. 18-22
OTOLARYNGOLOGY INTENSIVE COURSE

Mar. 4-8
CARDIOLOGY INTENSIVE COURSE

Mar. 14-16
SURGERY CONFERENCE

May 6-9
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

DEATHS

APPLEWHITE, CALVIN CRAWFORD. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1913; interned Burch Infirmary, one year; died Nov. 19, 1973, age 80.

RIDDELL, MAL S., JR., Winona. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1950; interned Knoxville General Hospital, one year; chairman of Board of Trustees, Mississippi State Medical Association, 1969-71; died Nov. 25, 1973, age 48.

SCHEDULE OF UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

Jan. 1-Jan. 13 — *The Exercise Prescription,* with Nanette K. Wenger, M.D., professor of medicine, division of cardiology, Emory University School of Medicine, and director of Cardiac Clinics and Program for Cardiac Evaluation and Medical and Vocational Rehabilitation at Grady Memorial Hospital, Atlanta, Ga.; and William L. Haskell, M.D., physiologist, Stanford University Medical School Heart Disease Prevention Program, Co-director, University of Stanford Cardiac Rehabilitation Program, Palo Alto, Calif.

Skylab: Clinic in Orbit, with Captain Joseph P. Kerwin, M.D., U. S. N., from NASA headquarters, Houston, Tex.

Office Screening for Chronic Lung Disease, with Spencer Koerner, M.D., chief, Pulmonary Medicine, Montefiore Hospital and Medical Center, New York.

Jan. 14-Jan. 27 — *Diagnosing the Inflamed Bowel,* with Marvin M. Schuster, director of Gastroenterology, Baltimore City Hospitals, and associate professor of medicine, assistant professor of psychiatry at Johns Hopkins University School of Medicine, Baltimore, Md.

Failure to Thrive, with Aaron R. Rausen, M.D., director of pediatrics at Beth Israel Medical Center, and Professor of Pediatrics, Mount Sinai Medical Center, New York.

Primary Treatment of Soft Tissue Injuries, with Ronald B. Berggren, M.D., professor and director of the plastic surgery division, Ohio State University College of Medicine; and Thomas S. Morse, M.D., assistant professor of surgery, Ohio State University College of Medicine.

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change.)

NEW MEMBERS

MEEK, EDWIN, JR., Greenwood. Born Greenwood, Miss., Feb. 8, 1943; M.D., Tulane University School of Medicine, New Orleans, La., 1968; interned Charity Hospital, New Orleans, La., one year; ob-gyn residency, same, 1969-1972; elected by Delta Medical Society.

LETTERS

SIRS: A chickenpox outbreak in an elementary school in Pontotoc was recently reported. During the period, Oct. 17-Nov. 13, 90 cases of an illness (characterized by mild constitutional symptoms and a generalized vesicular skin rash that appeared in crops and later became crusted) were reported. The overall attack rate for the school was 15.9 per cent over a 4-week period. The attack rate was highest in the first and second grades (24.0 and 25.2 per cent respectively). Twenty-nine children were taken to a physician and, in every case, the diagnosis was thought to be chickenpox. No children have required hospitalization and no cases have been reported in adults.

Nurses from the Pontotoc County Health Department contacted officials at 3 other schools in the county. Cases of chickenpox were recently suspected at one of these 3 schools. (Reported by R. L. Wyatt, M.D., Acting Director, Pontotoc County Health Department; Jimmie White Stegall and Faye H. Austin, Public Health Nurses.)

COMMENT

Chickenpox (varicella) is an extremely communicable disease, especially in the early stages of the eruption. Patients may transmit the disease to susceptible individuals as long as 5 days before the cutaneous eruption appears and up to 6 days after the first crop of vesicles become manifest.

Patients receiving steroids or other immunosuppressive therapy may develop severe and even fatal infection. A case of disseminated varicella in an immunosuppressed 4-year-old was reported from Lowndes County in January 1973.[1] If susceptible children with impaired immunity are exposed to chickenpox, Zoster Immune Globulin (ZIG) *if given within 72 hours of exposure* may prevent serious complications and death. ZIG is an unlicensed investigational drug and close clinical and serologic follow-up must be obtained for all ZIG recipients. Please call our office (354-6650) for further information and for assistance in obtaining ZIG if such therapy is thought to be necessary.

We encourage school nurses, school officials, day care center personnel and physicians in other regions of the state to report suspected chickenpox outbreaks to their local health department. In addition to varicella in immunosuppressed patients, our bureau is interested in reports of complications of varicella (mainly encephalitis and pneumonia) and varicella in adults; particularly, in pregnancy.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

REFERENCE

1. Disseminated varicella in a four-year-old child receiving chemotherapy. Mississippi Weekly Morbidity Report, April 13, 1973.

SIRS: The Bureau of Disease Control of the State Board of Health has been notified by the Viral Diseases Branch of the Center for Disease Control (CDC) of outbreaks of hepatitis-A related to the consumption of raw oysters in Georgia and in Texas.

Early results of an investigation by personnel from the CDC and the Food and Drug Administration have revealed that raw oysters implicated by food histories in both outbreaks were obtained from the same firm in Port Sulphur, La. The exact distribution of oysters from this firm and other firms fishing in the same vicinity has not been determined.

We are requesting that all practicing physicians in the state be alert to the possibility of shellfish-associated hepatitis-A in all patients they see with compatible clinical symptoms. In addition, we request that physicians alert our office (call 354-6650, collect) immediately of any suspected shellfish-associated cases so that we can participate in effective localization and control of this apparent interstate health hazard.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

Book Reviews

Questions and Answers on Contact Lens Practice. 2nd Edition. By Jack Hartstein, M.D. 221 pages with illustrations. St. Louis, Missouri: The C. V. Mosby Company, 1973. $12.75.

With an estimated million or more satisfied hard lens wearers and growing multitudes of satisfied Sof-Lens wearers it is obvious that contact lenses are here to stay. Our practices continue to swell with myopic maidens, athletes, and unilateral aphakes requiring more and more of our time devoted to contact lens practice. With newer developments on the horizon for therapeutic lenses, increased indications for prescribing contact lenses are right upon us. Thus the subject matter of this book becomes increasingly more important to all ophthalmologists.

The overwhelming success of the 1968 first edition requiring a second edition in 1973 suggests this book is well on its way to becoming a standard text. Dr. Hartstein is to be commended for his ability to cover such a broad array of contact lens subjects in such a concise, easy to understand manner. This book should be a must for residents and is extremely valuable to the busy practitioner as a quick office reference.

The book contains 29 short chapters in 221 pages in an easy to read question and answer style. The first seven chapters are devoted to basics, such as contact lens history, corneal physiology, slit lamp exam, keratometry, contact lens manufacturing and lab techniques for lens adjustments.

Chapters 8 through 17 cover actual fitting techniques with specific chapters dealing with myopia, aphakia, keratoconus, astigmatism, bicurve lenses, bifocal lenses, scleral lenses, and hydrophilic lenses. Chapter 16 is the Hartstein actual fitting technique in a compact six pages with enough information here alone for the beginning contact lens practitioner to fit his first pair of lenses. Chapter 15 covers other popular fitting techniques, such as P.E.K., Nomogram, and OC +2.

The remainder of the book covers a multitude of related subjects such as symptoms needing adjustments, how to correct a poor fit, fluorescein patterns, contact lens optics, cosmetics, contact lens solutions, and recent developments.

In a critical vein the chapter on hydrophilic lenses which had been added to update this edition still left me with a lot of unasked and unanswered questions. This chapter spoke in generalities and did not stack up with the rest of the book for concise, how-to-do it information.

In conclusion, I consider this book the Merck manual of contact lens and don't think a Scotchman could find a better buy at $12.75.

LEE H. ROGERS, M.D.
Tupelo, Miss.

Physician's Handbook. 17th Edition. By Marcus A. Krupp, M.D., et al. 727 pages with illustrations. Los Altos, Calif.: Lange Medical Publications, 1973. $6.50.

This seventeenth edition of *Physician's Handbook* contains an almost unbelievable amount of medical, diagnostic, and therapeutic information. The illustrations accompanying descriptions of diagnostic procedures (such as thoracenteses and liver biopsy) are exceptionally good. The volume continues to be of a size that can easily be carried in a coat pocket.

Thirty-two years have passed since the first edition of this handbook. During this time, medical knowledge advanced more than in all the preceding centuries of mankind. Medical practice has also changed. In 1941, approximately 80 per cent of all physicians were general practitioners. Today, general practitioners and solo practitioners are in the minority. This book devotes over 300 pages to diagnostic testing (x-ray, EKG, clinical lab). In 1941, solo practitioners had small office laboratories and either supervised the laboratory work or personally did it. A practitioner today has neither the time nor the expertise to do this.

What purpose does a volume such as this serve in 1973? It is probably of very little value to a physician in private practice. It should continue to serve the house officer as he gropes for a forgotten bit of knowledge during the nights while on the wards or in the emergency room.

JOHN R. WILLIAMS, JR., M.D.
Greenville, Miss.

PERSONALS

GEORGE BALL of Jackson has been elected vice chairman of the Mississippi Section of the American College of Obstetricians and Gynecologists. Dr. Ball will serve a three year term of office.

BLAIR BATSON of UMC met with the Easter Seal Research Foundation directors in Washington recently. He also served as an examiner for the American Board of Pediatrics in Miami.

HOWARD BEALE has begun his practice of ophthalmic plastic and reconstructive surgery at the Senatobia Eye Clinic on Norfleet Drive.

RICHARD BLOUNT and HOWARD CHEEK of Jackson are newly elected members of the 90 member executive board of the Andrew Jackson Council, Boy Scouts of America.

WILLIAM H. BOOTH, native of Maben, has joined the staff of the Marshall County Hospital in Holly Springs for the practice of surgery and otolaryngology.

FRED C. BORDELON has associated with D. C. MONTGOMERY for the practice of otolaryngology and maxillo-facial surgery at 124 South Broadway in Greenville.

HUGH P. BROWN announces the opening of his office for the practice of orthopedic surgery at St. Dominic Medical Offices, 971 Lakeland Drive in Jackson.

CURTIS W. CAINE of Jackson has been elected to the Board of Directors of the American Association of Physicians and Surgeons.

A. A. DERRICK, JR., of Durant, MSMA president, spoke at the Clarksdale and Six Counties Medical Society meeting held recently in Clarksdale.

DONALD E. DORE, JR., of Pascagoula was guest speaker at the commencement exercises of the third graduating class of medical technologists at the University of Southern Mississippi in Hattiesburg. Dr. Dore is a pathologist.

MABEL T. GARNER announces the opening of her office for the practice of medicine at 1215 S. Chrisman, Cleveland. Dr. Garner will also serve on the staff of the Medgar Evers Comprehensive Health Care Center in Fayette.

JAMES D. HARDY of UMC was a visiting professor at the University of Tennessee School of Medicine in Memphis in November.

WILLIAM H. HENDERSON of Oxford has been elected to membership in the Central Association of Obstetricians and Gynecologists.

JOHN JACKSON of UMC delivered the Harold Cummins Distinguished Alumnus Lecture at the Tulane Medical Alumni Association meeting in New Orleans.

WILLIAM JAQUITH of Whitfield was recently honored at an appreciation luncheon at Mississippi State University. Dr. Jaquith was on campus and in Starkville speaking to students about drug abuse.

SAMUEL B. JOHNSON of Jackson was a member of the company chorus of the Mississippi Opera Association's production of Pagliacci. Dr. Johnson also serves as chairman of the MOA board.

DAN T. KEEL, JR., of Brookhaven has been named council vice president of the Andrew Jackson Council, Boy Scouts of America.

FRANK T. MARASCALCO of Clarksdale is the new president of the Clarksdale and Six Counties Medical Society. Other newly elected officers are WHITMAN B. JOHNSON, JR., of Clarksdale, president-elect, and GERALD A. SMITH of Sumner, secretary-treasurer.

ROBERT MCBROOM, NICHOLAS DISANTI, GLYN HILBUN, W. J. MANUEL, WILLIAM BRIDGES and MATTHEW KULUZ were commended in a letter to the editor for their generous assistance to Girl Scout Cadette Troop 180 in the troop's "Medic Alert" badge project.

DEAN R. MCMILLAN of Jackson has opened an office for the practice of medicine in Madison at the Madison-Ridgeland Medical Clinic.

BENJAMIN P. MONACO of Pascagoula was recently certified a Diplomate of the American Board of Ophthalmology.

FRANCIS MORRISON of UMC attended the American Society of Cancer Education meeting in Hawaii.

BENJAMIN W. NUTT has begun the practice of medicine in Holly Springs in offices located in the Medical Center, adjacent to Marshall County Hospital.

CHARLES PRUITT, III, has joined the staff of the Medical and Surgical Clinic in Magee.

E. T. Riemann, Jr., of Gulfport was the honored physician at the November meeting of the Mississippi State Pharmaceutical Association, District 9, at Biloxi. A guest speaker at the meeting was C. D. Taylor, Jr., of Pass Christian.

John Russell of Gulfport was guest speaker for a session of the advanced first aid and emergency care course in progress in Hancock County. Dr. Russell discussed drugs and their abuse at the course which is sponsored by Hancock Emergency Medical Services.

Robert Sloan of UMC served as guest examiner for the American Board of Radiology examinations in Dallas in December.

P. K. Thomas of Tupelo has been elected to the executive committee of the North Mississippi Medical Center Corporation. The executive committee is in charge of the center's day-to-day operations.

Dan R. Thornton, Jr., of Meridian was elected chairman of District VII of the American College of Obstetricians and Gynecologists and has also been placed on the executive board of the college.

Gerald M. Walden of Ripley has been elected president of the Tippah County Hospital Medical Staff. T. L. Ketchum is vice president and Charles M. Elliott is secretary.

George W. Wharton has associated with Guy T. Vise, Jr., for the practice of orthopedic surgery at 971 Lakeland Drive in Jackson.

Stoney Williamson of Hattiesburg has been appointed by Governor Waller to the Mississippi Commission on Hospital Care. Dr. Williamson, an internist, will serve a six-year term, succeeding W. B. Winstead of Pascagoula. The commission's new chairman is H. J. Blakeney of Amory.

David Wilson of UMC met with the Committee on Graduate Medical Education in Washington, D. C.

Symposia Medica Plans G.I. Course

Symposia Medica Foundation presents an International Conference on Clinical Problems in Gastroenterology, to be held in Jersualem and Rome, Mar. 14-24, 1974.

For further information, contact: Ms. Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York, N. Y. 10010.

UMC Announces Two Faculty Appointments

Dr. Christina Gregg, assistant professor of psychiatry (sociology) in the School of Medicine, will also assume the position of assistant professor of family medicine. Dr. Donald Fisher, who is co-director of the physicians' assistant program at the Medical Center, has been appointed instructor in anatomy.

A graduate of Valparaiso University, Dr. Gregg got her master's degree from Indiana University and her Ph.D. from Purdue University. She taught at Purdue and worked as a sociologist with the Department of Health in Lincoln, Nebraska, before coming to Jackson.

Dr. Fisher graduated from Millsaps College and received his master's degree and his Ph.D. at the University Medical Center.

SBH Seeks Funds for Immunization

The Mississippi State Board of Health is asking for funds in the new Legislative Budget to acquire and administer a new triple vaccine for mass immunization against measles, mumps and German measles (rubella), says State Health Officer, Dr. Alton B. Cobb.

Made available to physicians in 1971 and used thus far in health departments only in the state of Massachusetts, "this vaccine may be administered by jet gun and immunizes the child against three diseases with a single injection," explained Dr. Durward Blakey, chief of the Bureau of Disease Control, State Board of Health. "This makes vaccination more convenient and spares children the discomfort of two additional injections. Although the cost of the vaccine is greater, in the long run the cost of immunizing the child is less due to the saving of additional visits to the health departments for immunization services."

"We must do everything we can to see that Mississippi's children are properly immunized," emphasized Dr. Cobb. "These so-called harmless childhood diseases are actually a very real threat to not only the child, but those exposed as well. German measles, for example, may cause very little discomfort to the child, but during 1964-65, 30,000 fetal deaths and 20,000 children born with birth defects were the results of a major rubella outbreak."

MFMC Receives PSRO Planning Grant

The association's Foundation for Medical Care has received a $24,000 grant from the Mississippi Regional Medical Program to begin development of a PSRO plan for Mississippi. The Mississippi Foundation for Medical Care was directed by the House of Delegates at the 1973 MSMA Annual Session to begin implementation of PSRO in Mississippi under requirements of Public Law 92-603.

A 23 physician member Committee on Professional Review Activities composed of Foundation members was formed during the summer and it was this committee which received the PSRO planning grant from the Mississippi Regional Medical Program.

A subcommittee of the Committee on Professional Review Activities is now developing the plan. The subcommittee is composed of Drs. Tom H. Mitchell, Vicksburg, Chairman; C. D. Taylor, Pass Christian; J. P. Culpepper, III, Hattiesburg; Richard C. Miller, Jackson; James W. Rayner, Oxford; and William H. Preston, Booneville. Dr. J. T. Davis of Corinth, president of the MFMC, serves as project director.

Staff Added to Health Related Professions School

Addition of two experienced professional nurses to the staff of the School of Health Related Professions at the University Medical Center will develop closer ties with hospitals and health care agencies throughout the state, says Dr. Thomas E. Freeland, dean.

Effective Dec. 1, Miss Ruth Werner and Miss Emelia Wellmann joined the health related professions staff as director of special projects and director of the clinical instructor training program respectively.

Miss Werner has been director of nursing service at the University Hospital since it opened in 1955. Miss Wellmann has served as associate director, also since 1955.

Miss Werner will help develop cooperative programs and teaching relationships with other educational agencies and hospitals. Miss Wellmann will coordinate short-term training for hospital employees in a joint Mississippi Hospital Association program.

Rondomycin®
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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes, exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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New York City Medical Examiner Addresses Northeast Medical Society

Dr. Milton Helpern, forensic pathologist and Chief Medical Examiner for the city of New York, spoke to the December meeting of the Northeast Mississippi Medical Society in Tupelo.

Dr. Helpern, who is considered a leader in the field of forensic pathology, was introduced to the group at the Tupelo Country Club by outgoing society president, Dr. John W. Bowlin of Tupelo.

Dr. Helpern talked to the physicians about the work of the legal medical examiners, as the profession is practiced in the U. S., and showed slides of a number of cases he has worked with as New York City's chief medical examiner.

He contrasted the medical examiner system, used in most of the counties in New York, with the coroner system employed by most states. He pointed out that most states do not require their coroners to be physicians and that, therefore, most coroner's posts are filled by laymen.

When the state legislature in New York set up the medical examiner system, however, it required that all medical examiners be doctors and that the chief medical examiner be a pathologist.

Dr. Helpern said a medical examiner had to be specialized to do any good. But he pointed out that it takes more than medical expertise to be a good medical examiner.

He said, for example, that an examiner should be able to get as much information from a naked-eye examination of a body as he does from his microscopic study.

He also said that knowledge of the circumstances of the death of the victim was often as important as a medical examination in determining the cause of death.

He noted that there is an extreme shortage of forensic pathologists and attributed the shortage to the fact that medical schools do not graduate enough pathologists for any to be "left over" for the specialized training required to become a forensic pathologist.

He also pointed out the importance of a medical examiner's office having a working relationship with a nearby medical school so that specialists can be consulted in difficult cases.

Dr. Helpern said the coroner system was a poor one, especially since the only usual requirement for holding the office is being eligible to run for public office.

In contrast, medical examiners are usually appointed by a civil service administration on the basis of competitive tests or by a commission.

He said the cause of death was not the most important information a medical examiner can supply to law officers. Often, he said, the points that determine who's a suspect and who isn't are not discovered merely by determining the cause of death.

He said suspicion in seemingly normal death is not usually aroused in the coroner system, but that it is the nature of a medical examiner to be suspicious of the death of any younger person.

He said such things as where and when a person died can make the death suspicious. Usually, when a report is made to the coroner, there is no suspicion of foul play unless there is evidence of obvious violence or there are easily noticeable wounds on the body.

But, he pointed out, any time a person dies at an age where natural causes of death would be unusual, the medical examiner will take it upon himself to determine the facts surrounding the case.

New officers of the society were also elected at the meeting. Dr. Dennis Ward of Corinth is the new district president.

Kidney M.D. Advisors Meet in Jackson

Members of the Medical Advisory Board to the Kidney Foundation of Mississippi met recently at the University of Mississippi Medical Alumni House.

The agenda included direct services and dialysis, transplantation, research related to kidney disease, professional education, public information and legislation.

Dr. Temple Ainsworth of Jackson is honorary chairman of the Medical Advisory Board. Dr. John D. Bower of Jackson is chairman; Jose M. Montalvo of Jackson, vice-chairman; and Karl W. Hatten of Vicksburg, secretary.

Members of the executive committee include Drs. George V. Smith, H. G. Langford and Lamar Weems, all of Jackson.

Among physicians serving on the advisory board are Drs. Ben B. Johnson, Helen B. Barnes, Sybil F. Raju, Charles E. Sledge and Joel L. Alvis, all of Jackson; George W. Vickery of Gulfport; and Gary Boone of Meridian.

Miss. Thoracic Society Elects Officers



Recently elected officers of the Mississippi Thoracic Society, medical section of the Mississippi Lung Association, are from left: Dr. John R. Williams of Greenville, president-elect; Dr. G. Boyd Shaw of Jackson, outgoing president; Dr. Fred Tatum of Hattiesburg, president; and Dr. Walter Treadwell of Jackson, secretary-treasurer. The thoracic society has a membership of 175 Mississippi physicians interested in pulmonary, respiratory and lung diseases and conditions.

Dr. Dabney Appointed to FLEX Committee

Dr. W. Moncure Dabney of Crystal Springs, a member of the State Board of Health, and Editor of the JOURNAL MSMA, has been named to the Federation Licensing Examination Test Committee, according to Dr. Alton B. Cobb, State Health Officer.



Dr. Dabney

The work of the FLEX Test Committee involves construction of the FLEX examinations, reviewing and debating policy, and reviewing and passing on results of examinations. There are 27 members on the commitee plus the chairman. Members are drawn from various states participating in the FLEX program.

In commenting upon Dr. Dabney's appointment, Dr. Frank J. Morgan, Jr., Assistant State Health Officer for Licensure and Certification, stated that "Dr. Dabney's contributions to the FLEX committee would indeed be a valuable asset. It is quite an honor for our state."

A member of the State Board of Health since Jan. 1, 1972, Dr. Dabney's specialty is family practice.

State medical examinations for licensure are given in June and December of each year in Mississippi, with the State Board of Health designated as the licensing agency for physicians, osteopaths and podiatrists.

Miss. March of Dimes Committee Meets

The Mississippi March of Dimes Advisory Committee held its annual meeting Dec. 5 at the Ramada Inn Coliseum in Jackson.

Guest speakers included Dr. Alfred Brann, Jr., director of the Newborn Center at the University Medical Center; Dr. Henry A. Thiede, professor and chairman of the department of obstetrics and gynecology, UMC; and Miss Elaine Whitelaw, director of volunteer services for the National Foundation. They emphasized progress being made on the state and national levels toward the prevention of birth defects and better care of

children born with defects. A film was shown which described the nurse midwife program in Holmes County, Miss.

Scott Hafen, 5, of North Las Vegas, Nev., the 1974 March of Dimes National Poster Child and his mother, Mrs. Gary Hafen, were special guests.

Dr. A. A. Derrick, Jr., of Durant, MSMA president, is a member of the MOD advisory committee. The association was represented at this meeting by Dr. James P. Spell of Jackson, Secretary-Treasurer.

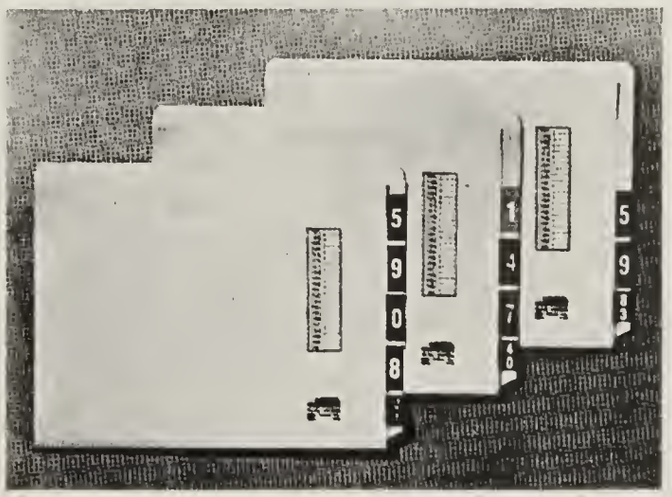
State MOD headquarters is located at 1603 Standard Life Building in Jackson. Mr. Owen Cooper of Yazoo City is state chairman this year.

CLASSIFIED

NEEDED: One physician to work in an active University Student Health Center beginning July 1, 1974. Please contact J. C. Longest, M.D., Director, Mississippi State University, P.O. Box 5448, Miss. State, MS 39762. Phone: 601-1-325-2431

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IN CONCLUSION

Subluxation of a vertebra, the theory upon which chiropractic is based, "does not occur," according to Edmund S. Crelin, Ph.D., professor of anatomy at Yale School of Medicine. In the Sept.-Oct. issue of American Scientist, Dr. Crelin reported that he examined the effects of pressure applied to the vertebral columns of six individuals within six hours of death. He noted that "the nerves did not become unduly stretched when the column was maximally twisted."

Emergency medical services bill, authorizing $185 million in federal aid for states and localities to set up emergency medical programs, was signed by President Nixon. An earlier bill containing a provision ordering the president to keep open eight U.S. Public Health Service hospitals was vetoed. Provision was removed and tacked onto a military measure. Communities receiving aid under new law are required to set up emergency telephone systems designating 911 as an emergency number.

A baby pacifier can be deadly - if hung around the infant's neck on a ribbon or string. Dr. V.J. DiMaio of Dallas, reporting in JAMA, said the Dallas County Medical Examiner's Office had encountered two accidental hangings of infants in the past six months, caused by pacifier cords. Dr. DiMaio also warned that a pacifier with a smaller than normal guard permits a baby to inhale it into his throat and suffocate.

A new kind of guidebook to Chicago has been published: it is strictly for the handicapped, mainly those persons confined to wheelchairs. Called, "Access Chicago," the project is supported by the Rehabilitation Institute of Chicago. Each hotel, museum, restaurant, etc., listing includes information on entrance and exit widths, elevators and other features, to assure the handicapped persons they can get in a place they want to visit.

According to a survey of 400 practicing physicians, the majority of U.S. internists and family physicians prescribe combination drugs and are generally aware of both their advantages and disadvantages. Results of survey were outlined by Dr. Louis Lasagna, chairman, Department of Pharmacology and Toxicology, University of Rochester School of Medicine and Dentistry, at a seminar on combination drugs in Washington. Participants included physicians, pharmacologists and FDA officials.

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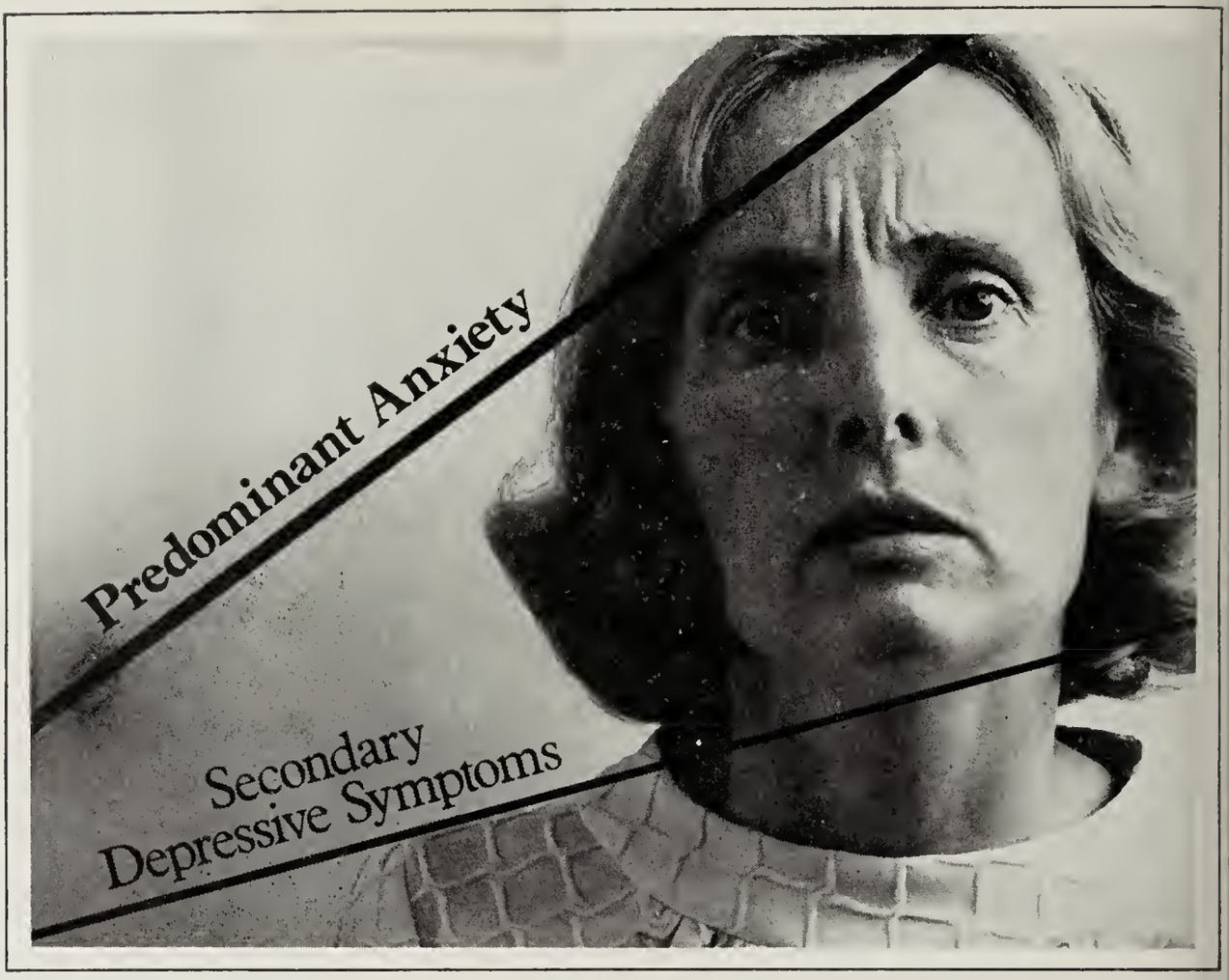
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Volume XV
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February 1974

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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Chinese Medicine and Acupuncture Meet Set

The second world symposium on acupuncture and Chinese medicine is being organized by The American Journal of Chinese Medicine with the cooperation of The American Society of Chinese Medicine and The Acupuncture Research Institute, and will be held in San Francisco Mar. 8-11, 1974.

The symposium will consist of two major sections:

(1) *Scientific Sessions*—these include lectures, presentation of scientific papers on topics of herbology, acupuncture anesthesia for surgical and dental operations, treatment of deafness, pain management and psychiatric problems, drug-withdrawal, etc., by means of acupuncture, the neurological basis of acupuncture and acupuncture anesthesia, classical acupuncture, current research in acupuncture and discussion of Chinese health care delivery and public health. Films will also be shown including those obtained from The People's Republic of China on topics including Chinese herbology and acupuncture anesthesia. An extensive exhibition area will allow registrants to observe recent developments in the United States in instrumentation and literature concerning Chinese medicine. Enrollment in the scientific sessions is open to all.

(2) *Training Sessions*—These consist of the training of physicians in the techniques of acupuncture and Chinese medicine as applied to normal individuals and patients with a variety of ailments.

For further information, please contact: Office of the Editor, The American Journal of Chinese Medicine, P.O. Box 555, Garden City, N. Y. 11530.

Fifth Family Medical Review

The University of Kentucky College of Medicine will present two identical, comprehensive reviews designed in part to prepare family physicians for the annual ABFM examination scheduled for late October. Approximately 70-74 topics will be presented by University of Kentucky and guest faculty.

The Fifth Family Medicine Review will be offered Sept. 15-21, 1974, and again on Oct. 6-12, 1974, at the University of Kentucky Medical Center. Program chairman is Dr. Frank R. Lemon. Registration fee is $195. Fifty hours of AAFP credit have been requested.

For further information, contact Dr. Ronald D. Hamilton, Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer

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NEWSLETTER

February 1974

Dear Doctor:

The medical profession led all major institutions in public esteem in two recent surveys. One conducted by Louis Harris and Associates for the Senate Government Operations Subcommittee showed that 57% of those polled expressed a great deal of confidence in the profession. Other rankings were universities, 44%; TV news, 41%; military, 40%; Senate, 30%; the press, 30%; major companies, 29%; House of Reps., 29%.

In the other poll, the National Science Foundation asked 2,220 adults to list nine professions in order of admiration and esteem. Physicians were first, scientists second, and clergymen third. Findings were reported by AMA's In Brief.

Mark your calendar now with the dates of the association's 106th Annual Session, set for May 6-9 at the Sheraton-Biloxi Hotel in Biloxi. Seven scientific sections have set up excellent programs in continuing education and the MSMA House of Delegates will make policy decisions. There will also be scientific and technical exhibits.

AMA headquarters will not be moved to Washington, D.C. The Board approved a report by its Ad Hoc Committee on AMA Headquarters Location recommending that at this time further consideration not be given to relocating in Washington, D.C., or in any area of the country other than Chicago or its environs. Deciding factor reported to be high cost.

A major new prime time TV series on health designed for an adult audience is being developed by the creators of "Sesame Street and will premiere on the 240 public broadcasting stations beginning in fall of 1974. The 26 original, hour-long programs will provide practical health information in an entertaining and instructional form.

A project to assess the effectiveness of a community program of services for physically abused and neglected children and their parents will be undertaken in Los Angeles under an HEW grant. Program will assess the impact of making available to the children and their parents extensive medical, legal and social assistance.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typieal lesions of moderately severe keratoses. Note residual searring on ridge of nose from previous eryosurgieal and eleetrosurgieal proeedures.



Patient P.T.* seen on 6/12/67, seven weeks after diseontinuation of 5% FU eream. Reaetion has subsided. Residual searring not seen exeept that due to prior surgery. Inflammation has eleared and faee is elear of keratotie lesions.

*Data on file, Hoffmann-La Roehe Inc., Nutley, N.J



DATELINE

Dermatologists Consult by Phone

Chicago, Ill. - Dermatologists seeking help with problem cases will have access to expertise of colleagues via telephone beginning in June 1974. Under the American Academy of Dermatology program, 64 dermatologists, primarily from teaching centers, have volunteered to receive long distance phone calls during a specified period each week from participating dermatologists. Roster will be distributed prior to June.

Medicare Time Limit Sought

Washington, D.C. - Proposed regulations establishing a basic time limit for filing requests for payment for Medicare services reimbursable on a reasonable cost basis were announced Jan. 9 by HEW secretary Caspar Weinberger. Services include those provided by hospitals and skilled nursing facilities. Deadline requires that a claim for payment for services be filed no later than a year after services were furnished.

Osteosarcoma Referrals Wanted

Bethesda, Md. - Cooperation of physicians is asked in referral of patients with operable bone or soft tissue sarcoma to the Surgery Branch, National Cancer Institute, to enter into a randomized study of Warfarin anticoagulation and chemotherapy as adjunctive measures to surgical treatment. Patients must have no evidence of metastatic disease and must not have received chemotherapy, radiotherapy or surgery.

Meeting on Cosmetics Laws

Chicago, Ill. - The government's role in regulating cosmetic products used by millions of Americans will be assessed at the AMA's Conference on Cosmetic Legislation Mar. 10-12 in Washington, D.C. For many years the least regulated of consumer product industries, cosmetic manufacturers have recently become the target of a succession of regulatory proposals. Participants will discuss product safety and ingredients.

NDA Clinical Research Subjects

Washington, D.C. - The National Institutes on Health's draft policy and procedures for the protection of certain human research subjects should specifically exempt clinical investigations in connection with new drug applications, Pharmaceutical Manufacturers Association said in comments submitted Jan. 8. NIH proposal outlines review mechanisms to protect persons with limited capacity to give fully informed consent.

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106th ANNUAL SESSION OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

May 6-9, 1974

at the

Sheraton-Biloxi

Biloxi, Miss.

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For fine food, hospitality and old world charm,
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WILLIAM W. SHINGLETON, M.D., Durham, N.C.
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WATTS R. WEBB, M.D., Syracuse, N.Y.
Surgery
JOHN D. YOUNG, M.D., Baltimore, Md.
Urology

SPECIAL SYMPOSIUM ON TRAUMA—Monday, March 11, 1:45 p.m.

Three Luncheons—Clinicopathologic Conference—Registration for Wives
Scientific and Technical Exhibits

This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by The American Academy of Family Physicians.

All Inclusive Registration Fee—$45

Send inquiries to: **The New Orleans Graduate Medical Assembly**
1430 Tulane Ave., New Orleans, La. 70112

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1974, Vol. XV, No. 2

ORIGINAL PAPERS

Cancer Control

A. HAMBLIN LETTON, M.D.
Atlanta, Georgia

The problems of cancer control-prevention, detection, treatment and rehabilitation—are discussed. Programs of the American Cancer Society and the new National Cancer Institute are described. The author also gives cancer occurrence and cure rates of the most prevalent types of cancer and solicits the support of the medical profession in public education toward the goal of earlier detection of cancer.

CANCER CONTROL is an elusive term—it varies between people, institutions, and even countries. The American Cancer Society understands that cancer control is the prevention of cancer, the early diagnosis of cancer, the early treatment of cancer when it is most curable, then the rehabilitation of the cured or uncured patient, and finally the care of the uncured patient during his last days. The National Cancer Institute, on the other hand, has a description of cancer control, in which they have been instructed by the Congress, that it is an overlapping of the areas of research, the developing of diagnosis and treatment techniques with patient care. In other words, they are interested in developing new methods of diagnosis and treatment and demonstrating that they are effective. The theory being that the taking of these methods to the patient is the responsibility of those agencies whose primary duty is patient care. Of course, the reason for this is obvious. Had the Congress instructed the National Cancer Institute to be responsible for cancer control as broadly as the American Cancer Society regards it, they would be in the business of patient care, which would be, in actuality, the socialization of a cancer patient's medical care with the government paying all the bills, which would put an awful strain on the taxpayer. The American Cancer Society, likewise, cannot financially afford patient care, but is the agency which is, in addition to doing research, attempting to educate the people and the physicians to utilize those methods research has already developed to the end that more patients will be returned to a normal healthy life.

Presented before the Mississippi Chapter, American College of Surgeons, Biloxi, May 1, 1973.

I was in Milan, Italy, a few years ago at a conference in which we were considering cancer control. I made the mistake of talking about control of cancer in the underdeveloped countries. I was immediately corrected that these were countries *under development* by Dr. El Sabai from Egypt. He and Dr. Chakaworti from Bombay, India, continued by pointing out that they knew that cancer control was important and would become more important as their countries became more developed, but at the present time, they were more concerned with supplying food, clothing, housing, and controlling communicable diseases in their developing countries than they were in cancer control. The latter did not, of necessity, have as high a priority as the other more pressing problems.

I suppose that this is the reason we are having difficulty in cancer control among some of the poorer socioeconomic groups in our own country. These groups are probably more concerned with getting food, clothing, and shelter than worrying about cancer.

I was in Warsaw and Krakow, Poland, last Oc-

tober in a meeting with the health educators behind the Iron Curtain. This was a very friendly and cooperative meeting, and many good ideas were exchanged. Dr. Glazier, the Professor of Surgery at Leipzig, East Germany, said that they had difficulty in teaching cancer control, although they realized its importance, because the government required that 25 per cent of the time in the curriculum at medical school had to be spent in teaching Leninism and Marxism.

CANCER ACT OF 1971

Recently, our country made a major commitment to attempt to solve the cancer problems when the President signed the Cancer Act of 1971, in which the Congress and the President pledged the support of our nation to the task with a high priority. The President said to us on several occasions that the act committed the Congress and the administration, but that they could not do the job alone. He said that the organizations, such as the American Cancer Society, American College of Surgeons, the medical profession, and even the people were needed if we were to conquer cancer in our lifetime. Every day I am happy that I am privileged to live in America.

The National Cancer Institute has been completely reorganized in the ensuing months. There is now a three-man panel which reviews the work of the National Cancer Institute each month and reports directly to the President. The National Cancer Institute now has a new director, Dr. Frank Rauscher, whose budget is to go straight to the President and not through the former channels of the Department of HEW. Dr. Brian Henderson is now the Director of the Division of Cancer Control. The major thrust of the National Cancer Institute is still in the research field, but another major project has been initiated, that of building new cancer centers in geographically strategic areas. These centers will, likewise, take part in the research program, trying to find the cause, prevention, and more effective treatment of cancer. But they will also demonstrate to the surrounding community the latest and best cancer care, so that the medical profession and the health care delivery organizations of that area may do a more effective job of caring for the cancer patient.

The Cancer Control Division, along with the American Cancer Society, is now tooling up to put 27 breast screening projects into operation. The aim of these projects is to find better ways to do mass screening in order to detect cancer of the breast at a more curable time, and also to better define the high risk groups. This emphasis is due to the fact that cancer of the breast[7] is the number one killer of women. There are roughly 70,000 new cases yearly with 31,000 deaths each year from cancer of the breast. These figures are hard for us to realize unless we translate them into the experience of our everyday lives. New cases of cancer of the breast each year would fill Yankee Stadium with "Standing Room Only"—more women develop cancer of the breast than the total automobile accident deaths in the United States each year—in 10 years, the incidence of breast cancer exceeds the population of Boston, Massachusetts—in the years of the Vietnam War, more than eight times as many women have died of cancer of the breast as servicemen have died in combat in East Asia. One out of every 15 newborn girls will develop cancer of the breast. In every 17-minute period three new cases of breast cancer will be diagnosed, and in those same 17 minutes, one woman will die of cancer of the breast. We know that a cancer of the breast that can be felt is not an early cancer. It has been present for many months, and if we are going to further increase the cure rate, we must diagnose these cancers earlier.

CANCER OF THE CERVIX

The Cancer Control Division is undertaking to find why more women have not taken advantage of the benefit of the Pap smear in diagnosing early cancer of the cervix. Only 53 per cent[12] of the women in our United States have ever had a Pap smear, and only 25 per cent are having one regularly. In fact, the number of women having regular Pap smears has decreased in the past few years. A survey of 10 areas in the United States reported that for every 100,000 white women, cancer of the cervix occurred in 50; for every 100,000 nonwhite women, this type of cancer occurred in 89. Among all women in this country, cervical cancer incidence is second only to cancer of the breast, but in the low income groups, it is more prevalent. In Atlanta, a few years ago, a mass screening in one of the ghetto areas showed that for every 100,000 women, 109 of them had cancer of the cervix. A Gallup pole reported that 45 per cent of the white women had at some time had cancer detection tests while only 28 per cent of the nonwhite women had at some time had a cancer detection test. The reasons for these are multiple: (1) Low income women are unable to pay for private doctors and probably lack the means

of transportation to public clinics for preventive medicine measures. They have to feel sick to afford the carfare. (2) Widespread functional illiteracy is a problem that leads to misconception about cancer and its curability, importance of the Pap smear, and the physiology of the reproductive system. The terminology of the medical profession is not understood and often creates needless fears. (3) Educational programs which are unrelated to immediate available services are not relevant. These women are high risk in terms of invasive and terminal cancer because detection and diagnosis is not available or accessible. Data indicated a causal relationship between uterine cancer and early sexual activity. The term "under 20 at risk" refers to the younger women who have begun to make sex a part of their life. There is a high correlation between all these factors in low income ghetto residencies. In addition to these women, there is a second target group, and this is the older women who grew up when the Pap smear was not commonly accepted and has not had a checkup since her childbearing years. The need is for recruitment of postmenopausal women for regular examination.

Cancer of the endometrium is primarily a disease of the mature woman. Most cases are diagnosed in the 50's and 60's. About 75 per cent[12] of all endometrial carcinoma is diagnosed after the menopause. Life expectancy of American women has increased dramatically. It has gone from 49 years in 1900 to 74 years in 1968. So more women are reaching an age when endometrial carcinoma occurs more frequently. The 1970 census shows that 45 million women are 35 years of age or older. Of these, an estimated 700,000 will eventually develop endometrial carcinoma.

One Pap test in a woman's life is not enough. Again, changes in her body and other variables make it necessary to have regular checkups. If very woman had the test every year, most uterine cancer could be discovered in time for cure. These are the reasons that the American Cancer Society has initiated a new effort to get every woman over 20 to have a Pap smear. The American College of Surgeons last January at the meeting of the Approvals Committee of the Cancer Commission in New Orleans asked all hospitals to do routine Pap smears on every woman admitted.

There are a few projects that the National Cancer Institute is preparing in its present reorganization. There are others being developed.

But let's talk about the American Cancer Society, which has undergone a metamorphosis in the last few years. It is still engaged, even more deeply, in the research effort, but it has added emphasis to its programs of education, service, and rehabilitation. These are terribly important jobs. More Americans died of cancer last year than were killed in World War II. We are elated that the cure rate has risen from 33 per cent[5] of a few years ago to 40 per cent of all people having cancer today being cured. This is great, but the possible cure rate, that is the number that could be cured if the cancer is correctly treated as soon as it can be diagnosed, has risen from 50 per cent to 67 per cent. Here are 27 per cent of cancer patients who are unnecessarily dying. Why? Because, they either do not know to come for treatment or are afraid to come, or because some health care provider failed. In one word, what are we saying? Education—public education and professional education. We must do a more intensive public education program, reaching more people, telling the story over and over again. I have mentioned the Pap Smear Program. The death rate of cancer of the cervix has decreased markedly, yet cervical cancer remains a major problem. The diagnosis and treatment of cancer in situ of the cervix costs much less than $1,000, while the diagnosis and unsuccessful treatment and the caring for of the woman with advanced cancer of the cervix during her dying days and the care for her motherless offspring will cost from $15,000 to $20,000. Somewhere, someone must be responsible for this debt. Some of these are our patients and neighbors, while others are in the lower socioeconomic group, who must be cared for by the government. Thus, because a simple test was not done, our patients or neighbors go bankrupt, or your and my taxes must be increased for the government to care for them. Just another good reason why we should be interested in getting Pap smears on everyone.

SELF-EXAMINATION

Until such time as we can have a better and more widely usable breast screening program, we must rely on the best self examination program to get the women to the physicians as early as possible. The mortality rate[4] of cancer of the breast has remained nearly 25 per 100,000 for the last 40 years. However, this does not mean that we are not improving our cure rate during this period of time. It is coincidental that the incidence rate has increased the same as the cure rate has increased. In Connecticut[1] where the State Registry has been active for a number of years, the incidence rate has increased from 55 per 100,000 in 1940-1944, to 74 per 100,000 in 1965-

1968, which means that we are curing about 20 per cent more women now than we were curing 30 years ago. In fact, when you divide the incidence by mortality, in 1940, it was 1.91 and by 1960, it was 2.4. This is due, in the main, to earlier detection, for the treatment of this malady has experienced very little change in this period of time. Collected statistics show that only 45 per cent of patients with cancer of the breast who have positive axillary nodes are being cured, while 84 per cent can be cured when there is no nodal involvement. Statistics, therefore, show that through the educational efforts, mainly of the American Cancer Society, we are treating earlier breast cancer today than ever before. Our efforts are paying off, but not enough. We must still rely on the breast self examination program which teaches the woman to search her own breasts for some change in its physical character each month and immediately report the change to her physician. Gilbertson[8] at the Cancer Detection Center at the University of Minnesota, where some 8,000 women, 45 years or older, have undergone 46,000 annual examinations, has reported that in those in which cancer of the breast was found, the annual exam finding the cancer early has resulted in an observed survival rate of 96 per cent, 85 per cent, and 82 per cent at the 5, 10, and 15 year intervals, which is a relative survival rate of 104 per cent, 105 per cent, and 119 per cent at these same intervals. This dramatically shows that early cancer of the breast can be detected by annual physical examination. We must teach breast self examination. We must also increase the physician's suspicion of cancer of the breast and develop screening methods. Just last week, we operated on a lady with cancer of the breast whose local internist had told her, "This mass must be mastitis. I believe I felt it last year," and yet when she went to her gynecologist, he referred her to us and she had a 2½ cm. carcinoma of the breast. It was almost a miracle that after the first physician saw the mass and still did not suspect cancer that she happened to see someone who did suspect it was cancer. We have to raise the suspicion of physicians with regard to cancer of the breast.

Cancer of the lung continues to kill more and more of our people, both the male and the female. The amount of cigarettes sold[3] shows a steady increase. Eighty-five per cent of the cancers of the lung are caused by smoking and can be prevented by not smoking. If all cigarette smoking was eliminated, the prevention of cancer and the curability of all cancers would rise from 67 per cent, which I have already mentioned, to an almost unbelievable 75 per cent.[13] Seventy-five per cent of all cancer could be either prevented or cured. Yet, we are still at 40 per cent cure—60 per cent not being cured. There are some interesting statistics on the amount of smoking that is done in America today. In the five years from 1965 to 1970,[11] the percentage of adults smoking dropped from 41.6 per cent to 36.7 per cent. The largest percentage, however, was found in the males, which dropped from 51 per cent in 1965 to 43 per cent in 1970. The females only dropped from 33 per cent to 30 per cent. Among those teenagers of 17 years or less there was an increase in the *heavy* smokers. In 1968, 11 per cent of the boys were smoking, and 6 per cent of the girls. By 1970, 14.7 per cent of the boys and 9 per cent of the girls were smoking, and by 1972, 12.8 per cent of the boys and 11 per cent of the girls. However, in the 18-year-olds in 1968, 35 per cent boys and 21 per cent girls smoked, and by 1970, 42 per cent boys and 27 per cent girls. In 1972, 32 per cent boys and 24 per cent girls were smoking. The fact remains that the total number of cigarettes smoked per year per person has remained fairly constant, which means that those who are smoking are smoking more than previously. However, in the year of 1963,[2] 58 per cent of the cigarettes sold were filters, whereas in 1971, 82 per cent were filtered, which means in spite of the fact that they are smoking more, they are probably not getting as much harm out of it. The fact still remains that too many people are smoking for us to be able to control carcinoma of the lung, and the death rate continues to climb. The problem really is at present that the youth are starting to smoke in too great numbers. We must convince them not to smoke—it is so much easier not to start than it is to try to stop later. The program of getting adults to stop smoking, as you have seen, is doing fairly well but over one-third are still smoking. Many more than 29 million adults have stopped smoking. Well over 50 per cent of the physicians who smoked have stopped.

Cancer of the colon is the most frequent malignancy found in both the male and the female, and we really do not have any easy way of discovering this tumor early. Seventy-one per cent[6] of cancer of the colon occurs within the range of the sigmoidoscope. Proctosigmoidoscopy of all those over 40 is a miserable thing for both the patient and the physician and has not been easily accepted. We had all hoped that the carcino embryonic antigen test would help us. Dr. Phil Gold of Canada[9] has found that the

carcino embryonic antigen (CEA) is present in cancer of the colon, but the test is so sensitive that it finds positive results in some very small tumors—tumors which cannot be located by our usual methods and therefore, it is rather distressing to tell the patient, "Your test is positive, but we don't know where your cancer is located." The CEA test is also technically impossible to do in the ordinary laboratory. So, we must have more work and refining done on the carcino embryonic antigen test. We, as a second choice, then, must have a wider use of the hemoccult test[10] for blood in the stool, which can be done in any office or laboratory or even at home by the layman. We must make the patient and the physician more aware that bleeding may be cancer. Dr. Barton MacSwain[7] reviewed the experience of cancer of the colon in Nashville over the 10 years of the 1960's and found the patients delayed three months going for medical care after bleeding occurred, and then there was a 2.5 month delay after the physician saw the patient until the diagnosis of cancer of the colon was made. Everyone, patient and physician alike, assumed the bleeding was hemorrhoids. This is much better than 25 years ago, but we must do better. You see the problems of education—you can see why you must play an important part in this program if we are to accomplish our goals.

We must impress the public that we can cure them if they will only come for treatment early enough! We must help them to realize that cancer is not necessarily a hopeless disease as it was supposed 59 year ago when the American Society for the Control of Cancer was first formed. We must mount a more intensive public education program. Curing the patient of cancer does not necessarily, in itself, insure quality of survival. It makes little sense to cure a person of his disease and not bring him back into a useful, happy life. It is found in St. Matthew, "What does it profiteth a man if he gains the whole world and loses his soul?" We can paraphrase this by saying, "What does it profiteth a man to cure him of cancer if he loses his ability to live?" What does it profiteth a man if he loses his leg to cure him of cancer and you don't teach him to walk? What does it profiteth a man if you cure him of cancer of the larynx by removing his voice box and don't teach him to communicate? What does it profiteth a man if you remove his colon to cure him of cancer and leave him with an uncontrolled colostomy that makes him repulsive to himself, his family, and his friends? We must teach him how to properly care for the colostomy that it may be controlled. What does it profiteth a woman if you remove her breast to cure her of cancer and she no longer feels feminine? In this bosom-conscious society of ours, she feels that she has lost her sex appeal, that no one will love her, that she can't wear pretty clothes or a bathing suit. We must have the Reach to Recovery Volunteers help this woman to rehabilitate herself and teach her the exercises and how to wear clothes—that she may live a normal life again. These are so important for only in these ways can we insure the quality of life.

This is but a short resume of the problems of cancer control—it is a difficult and elusive thing—it is for us to do so much! Seventy-five per cent of the cancers can either be prevented or cured!—yet 60 per cent of the victims are succumbing to this disease! We need help in educating the public.—We need help in educating the medical profession. It is our duty—yours and mine—to do this task—to accomplish this goal of conquering cancer in our lifetime. As President Nixon has said, the Congress and the executive branch of the government are committed, but there is much that they cannot do. So much depends on the medical profession and the volunteer laymen.

Here in the country with the best medical talent and facilities in our world, it is a shame that we still have 60 per cent of our cancer patients dying of this disease. ★★★

340 Boulevard, N.E. (30312)

REFERENCES

1. Cancer in Connecticut, Incidence Rates, 1935-1964. Connecticut State Department of Health, Hartford, Connecticut.
2. Cigarette Smoking in the United States, 1970. Federal Trade Commission Report to Congress, 1971.
3. Cigarette Smoking, 1970. Vital Statistics National Center for Health Statistics, June 2, 1972.
4. Cutler, S. J., Christine, Barbara and Barcleay, T. H. C.: Increase Incidence and Decreasing Mortality Rates for Breast Cancer. Cancer 28:1376-1380. December, 1971.
5. End Results in Cancer. Report No. 4. U. S. HEW Publication No. (NIH) 73-272, 1972.
6. Facts and Figures. American Cancer Society, 1972.
7. Franklin, Robert and McSwain, Barton: Carcinoma of Colon, Rectum and Anus. American Surgeon 171:811-818, June, 1970.
8. Gilbertson, V. A. and Kyelsburg, M.: Detection of Breast Cancer by Periodic Utilization of Methods of Physical Diagnosis. Cancer 28:1552-1554, December, 1971.
9. Gold, P.: Circulating Antibodies against Carcinoembryonic Antigen of Human Digestive System. Cancer 20:1663-1667, 1967.
10. Gregar, D. H.: Occult Blood Testing for Detection of Asymptomatic Colon Cancer. Cancer 28:131-134, 1971.
11. Patterns and Prevalence of Teenage Smoking 1968-1972. National Clearing House for Smoking and Health.
12. Situation Analysis. National Task Force for Uterine Cancer. American Cancer Society, February, 1971.
13. Statistical Department, American Cancer Society.

Combined Hepatic and Vena Caval Injury: A Technique for Control of Hemorrhage

JOSEPH F. WELDY, M.D.
Vicksburg, Mississippi

BLUNT TRAUMA to the liver with associated injury to the retro-hepatic inferior vena cava has carried a high mortality due to massive hemorrhage. Avulsion of a hepatic vein leaves a large defect in the vena cava, a structure which does not lend itself to conventional methods of vascular clamping. A partial-occluding clamp such as the Satinsky is occasionally useful, but usually there is not sufficient exposure to allow its use. Schrock[1] has described a technique of bypassing the vena cava with an internal shunt from the right atrium to a point below the renal veins. In massive injuries this technique can be life-saving. However, we have recently had a case of lesser magnitude in which a simpler procedure was utilized and worked quite satisfactorily.

CASE REPORT

A 15-year-old girl was examined after an auto accident. Though not in frank shock, she showed signs of hemorrhage and complained bitterly of epigastric and left upper quadrant pain. Tenderness with rebound was present. Chest x-ray was normal, and urine was clear. Laparotomy revealed hemoperitoneum. A deep laceration was noted on the lateral segment of the left lobe of the liver, just left of and parallel to the falciform ligament and extending over the dome of the liver. The midline incision was extended to the xiphosternal junction. Minor bleeding from the liver laceration was controlled by suture. Hematoma was noted in the region of the junction of the left hepatic vein and the inferior vena cava. This area was approached between the diaphragm and the dome of the liver. For exposure, the falciform ligament, the left triangular ligament, and the medial portion of the right triangular ligament were divided. As this dissection was in progress, massive venous bleeding occurred.

The author gives a case history of injury of the retro-hepatic vena cava with resultant bleeding from the retro-hepatic inferior vena cava. The case illustrates use of an intravascular balloon tamponade of the vena caval defect with a Foley catheter to control bleeding and allow suture of the defect.

Control was obtained with a fingertip placed in a defect in the anterior surface of the vena cava, apparently the result of avulsion of the left hepatic vein. Further exposure was then obtained by incising the central tendon of the diaphragm into the pericardium[2] and opening the vena caval hiatus of the diaphragm.

Despite these maneuvers, suture of the defect was impossible due to the massive bleeding that occurred whenever the finger was withdrawn. Bypass through an internal shunt was considered, but a simpler technique was attempted in hopes of avoiding thoracotomy. A standard Foley catheter with a 5 cc. bulb was passed into the vena caval defect. The bulb was inflated and gently pulled outward against the defect. Ten cc. of saline was required in the bulb to control the bleeding, and this apparently did not obstruct the vena cava, as there was no drop in blood pressure. Suture of the defect was then readily accomplished, though care was necessary to avoid puncturing the bulb with the needle. The catheter was removed as the final sutures were tightened. After this, the lateral segment of the left lobe ap-

From the Department of Surgery, Vicksburg Clinic, Vicksburg, Miss.

peared swollen and congested and was resected by finger fracture and ligature technique. Ten units of blood were given during the surgery. Postoperative status was stable, and recovery was satisfactory.

Extravascular balloon tamponade has been useful in control of bleeding from a variety of sites such as nose, esophagus, and prostatic fossa. This case illustrates use of intravascular tamponade in the difficult problem of injury of the retro-hepatic vena cava.

SUMMARY

A case is presented of blunt injury of the left lobe of the liver and avulsion of the left hepatic vein with resultant bleeding from the retro-hepatic inferior vena cava. Technique of exposure of the injury through a laparotomy incision is described. Initial control was obtained by a fingertip in the vena caval defect. Temporary intravascular tamponade of the vena caval defect with a Foley catheter allowed suture of the defect. The lateral segment of the left lobe of the liver was resected. Recovery was satisfactory. ★★★

Vicksburg Clinic (39180)

REFERENCES

1. Schrock, T., Blaisdell, F. W. and Mathewson, C.: Management of Blunt Trauma to the Liver and Hepatic Veins. Archives of Surgery, 96:698- , 1968.
2. Heaney, J. P., Stanton, W. K., Halbert, D. S., Seidel, J. and Vice, T.: An Improved Technique for Vascular Isolation of the Liver: Experimental study and case reports. Annals of Surgery, 163:237-241, February, 1966.
3. Allen, R. E. and Blaisdell, F. W.: Injuries to the Inferior Vena Cava. Surgical Clinics of North America, 52:699-710, June, 1972.

He managed to get out of Northern Ireland. When his plane landed in New York, reporters swarmed around with questions. "Look," the Irishman protested, "you fellows take the smallest incident and magnify it just to sell your papers. We're really a very peaceful country. The Catholics get along with the Protestants, we all get along with the British army and IRA is really a benevolent organization."

The reporters thanked him for setting them straight. Then one of them asked, "By the way, sir, what do you do for a living?"

"Who, me? I'm a tail gunner on a bakery truck!"

Public Health: Past, Present and Future

DURWARD BLAKEY, M.D.
Jackson, Mississippi

CONCERN; even preoccupation, with the forces influencing morbidity and mortality is evident from mankind's earliest memory. Myths and legends are heavily endowed with such references and with rituals and remedies. A knowledge of medicine, often in the accepted sphere of public health practice, is prominent in art and literature. Even a cursory examination reveals it to be one of the oldest professions.

Perhaps the first public health law was the admonition to Adam. Brief, it was adequate to the subject, though, like much subsequent law, not overly indicative of underlying rationale. The larger compendium, comprising the first sanitary code, was established later by the Hebrews. Moses, the codifier, has been called the first teacher of preventive medicine. He should have the title of first state health officer as well, since his organization of priests enforced the code. People were taught to maintain high levels of personal hygiene and were instructed in principles of excreta disposal, protection of food and water, prevention of disease and maintenance of the environment. The priests required disease reporting after a fashion, established or enforced isolation and quarantine and supervised rites of purification.

Time and understanding have not dimmed the validity of Mosaic laws. Rather, we marvel at their integrity in the absence of any recorded, contemporary scientific rationale. Such beginnings had to await Hippocrates and the enunciation of interaction of natural laws. His exegis was a rule of personal hygiene which would avoid conflict with such natural forces. The physician was taught to evaluate the patient in this total context in order to arrive at a correct diagnosis with proper therapy—a concept being applied more recently in modern health planning.

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Ancient civilizations enjoyed levels of public health unknown to us until the most recent times. Besides the Greek systems, the Romans made their cities comfortable by pioneering in safe water supplies and sewerage systems. Environmental sanitation was their hallmark but governmental concern extended to personal hygiene as evidenced by the provision of public baths.

A brief overview of the growth of public health practice within the medical sphere from the earliest time to the present is offered. The development of the "right to health" concept and its delivery as being the central role of government are examined. The probability of a national health care system is entertained and possible roles for public health are suggested.

From the decline of the Roman Empire until the latter half of the 14th century, public health was lost. Seemingly, nothing was remembered of the past health practices and epidemics were commonplace. Then, quarantine was imposed by a few cities against shipping arriving from certain areas. Not until Vesalius' anatomy treatise (1543) did physicians learn anew about the human body. A century more was to pass before the microscopic world was discovered and the latter half of the 18th century before public health consciousness truly began to awaken.

It is said that physicians, working with lay philanthropists, reduced infant mortality in England by 50 per cent between 1770 and 1800.[1] Still, throughout the early part of the 19th century, none thought to consider the effects of the sweat houses and work rooms; unsanitary and overcrowded slums with their relationships to disease epidemics—never so evident as in the cholera outbreaks in England in 1831. While devoted efforts achieved shorter work-

ing hours under better conditions, it remained for Edwin Chadwick, Secretary of the Poor Law Commission (England) to, in 1842, draw attention to the relationship between disease and slums. This started the move toward sanitation and good housing, the basis of public health to the present day.[3] Both Europe and America evidenced a growing concern over the need for public hygiene and, constantly spurred by epidemic episodes, fear joined humanitarianism in the demand for clean-up. The consequent investigations, reviews and reforms led ultimately to the 20th century awakening of the public health conscience whose cornerstone in the United States was laid in the *Report of the Sanitary Commission of Massachusetts, 1850.*[1]

Heavily influenced by the European experience, the Shattuck Report[2] outlined the basis for sound public health practice. With uncommon foresight, failing only to foresee bacteriology and the biologic revolution, this remarkable architect listed some 50 recommendations. Rumsey lists those which have been realized in large measure:

1. establishment of state health departments;
2. provision for local boards of health;
3. conduct of sanitary surveys of particular communities, chosen for cause;
4. vital statistics registration; including:
   a. decennial census;
   b. standard nomenclature of causes of disease and death; and,
   c. registration of data by age, race, sex, occupation, economic status and locale;
5. environmental sanitation;
6. food and drug control;
7. communicable disease control, with stress on vaccination;
8. well-child clinics;
9. school health program;
10. mental health program;
11. smoke control;
12. alcoholism program;
13. town planning; and
14. teaching of preventive medicine.[1]

The temptation is strong to stop here and play expansive variations on Shattuck's theme; to detail with pride our progress to the present pinnacles; to assure ourselves that all is well in our sphere of endeavor. But the history of public health is not so much of superior accomplishments as of missed opportunities. To obtain any clarity in the prospectus, an understanding of the impasse in which medicine finds itself today is essential.

Jenner began the promotion of smallpox vaccination as the 19th century opened. In those early years, because of cost, the procedure was limited to private practice. Yet, the Mississippi legislature provided for those who desired it in the 1830's and authorized a vaccine depot for the entire state in 1846. In this same period, in recognition of the dependency of the state's health on its physicians, the legislature provided for their membership in a voluntary state department of health. Perhaps influenced by the Shattuck report, the leadership of our profession sought, and secured in 1877, an official state health agency. Under their guidance it has grown to its present position. In no other state has such a partnership resulted wherein the official health agency numbers every member of the profession as a part.

But, whether in Mississippi or nationally, our predecessors generally knew the importance of the public health method of study and investigation. They convinced their legislators that reportable disease lists were essential and solons, content with medical leadership, gave them absolution to conduct business in the public interest. None of this occurred overnight nor was such enlightenment the province of many. The important point has been medical leadership and such gains as have been made rest on this background.

But what has happened to our storied partnership? Our medical schools are not teaching much about the mission or function of public health and some graduate schools are said to be reducing emphasis on epidemiology. Physicians seek legislation to abolish disease reporting simply because the patient is "private." Lay hospital administrators obstruct or refuse essential control information and, seemingly, visualize the health system in terms of the skills and facilities under their control. State vies with federal government in efforts to dominate medical institutions and the in-fighting in both spheres includes the efforts of various groups to maintain disciplinary integrity; to avoid being dominated or absorbed or subjugated and, if necessary, willing to accept responsibilities in wider spheres of service. Some say we are not serving the greater need of our profession; others, that we are forgetting the patient. Perhaps both are right and, if we seem to have fallen on hard times, maybe we have confused the rock with a hard place.

From the early part of this century, there has been an increasing public call for more and cheaper

medical services. Lately, a diffident national government has essayed to enter the lists, terming the outcry an evidence of the "crisis in medicine." Overlooking the plethora of pronouncements on "crisis," the cant of which must be to the interests of the several authors, the single common factor is the call for a government program to deliver the very best medical service (preferably, preventive; *i.e.* no illnesses) at a nominal (preferably, no) cost to the recipients.

Reviewers like to describe the modern era of public health as one of great attainment. The truth is the surface has been scratched. We stand on the threshold but, aside from some advances in chemotherapy (particularly, the ability to deal with syphilis and tuberculosis) nutritional diseases and some endocrinologic disorders, the only true technology in medicine is that of immunization.[19] While the solution to our problems rests with the development of such technology, the survival of medicine as the dominant discipline stands in some doubt. Mary Louise Barker cites hospital, political and lay organization leadership as those who have grabbed the impetus and "we, as physicians have allowed all aspects of medical care to come under lay control."[4]

Public health has always been a part of the profession of medicine. Ancient civilizations understood the necessity for subjugating certain individual rights to the common welfare. The establishment of this concept in modern public health law should be clear enough. However, it has occasioned a fundamental divergence. Setting apart the concept of "government" medicine versus private, it introduces the millstones of "enforced" as opposed to "voluntary." From this stem other artificial divisions such as "charity" and "pay" patient, "preventive" versus "curative" medicine and all the other attempts to rationalize medicine into the two great arenas of public health and private practice. A great deal of time, effort (and spleen) have been devoted to finding a common denominator which would neatly define the sphere of public health and thus continue the peaceful, if sometimes nervous, co-existence of the two.

The futility of this approach has been summarized by Dr. Sammons, Vice-Chairman of the Board of Trustees, American Medical Association (AMA). He believes that too many physicians hold the shortsighted view that the only purpose of their practices is to meet their needs and the needs of their patients; and, that the purpose of the profession, including county and state medical societies, is to protect individual practices. Dr. Sammons defines "profession" as the sum total of medical and ethical standards and adds: "While his patients must claim first priority, he must also practice enlightened self-interest by supporting the larger profession" . . . which is "dedicated to preserving and improving the total medical environment: the pluralistic system, high quality medical education and effective planning of such programs as continuing education, public health and health education." Each physician must recognize his three obligations: to his patients; to his profession and, to the public.[5]

Public health has been gratuitously sobriqueted as guardian of preventive medicine, environmental protector, guarantor of the wholesomeness of food, milk and water, inspector of public buildings and its practitioners as "Sanitarians." Traditionally, in this country, the classic medical practice, that of attending sick people, has been foresworn to public health. The accepted area of patient care, prevention, is embodied in programs such as well-child and school health. We have been expected to educate and vaccinate. Where these measures were inadequate or inappropriate, special programs have provided treatment and, sometimes, rehabilitation. Perhaps no other country has gone to such lengths to keep its government from taking an active role in the personal health care field. Only environmental control has been generally accepted as the proper sphere for government (public health) action and those who recognize the existence of health related social conditions are often dismissed as "social planners" or worse. Obviously, the third is part of the other two and none can stand alone.

Somewhere, there seems to be agreement, we have lost the ball and, if medical leadership be the ball game, are in fair way to lose that as well. The public health services are in the throes of massive reorganization efforts at national and state levels. There has been, evidently, loss of confidence in the capacity for traditional public health to deliver more comprehensive services. Because of consumer group pressures, federal developments during the 1960's bypassed and still threaten the very existence of state and local health departments. Since there is neither a national health policy nor a stable health organization, the federal-state-local "partnership for health" is still largely a myth and comprehensive health planning leads to further fragmentation and less coordination of health services than ever.[6]

Why has public health failed to provide comprehensive health services? Cleere lists these points:

1. lack of support by organized medicine (societies) and other professional groups;
2. failure of public health agencies to "sell" the public or key office holders on the importance of our mission;
3. dearth of public health physicians;
4. provincial attitudes of officials; and
5. proliferation and fragmentation of health agencies and services, secondary to:
   a. loss of confidence in public health leadership;
   b. clamor for space by activists with vested interests in other fields; and
   c. demands of special interest groups.

Illustrative of the last point in particular; the establishing of new environmental control agencies when it is accepted that environmental and personal health are inseparable; and, separate mental health agencies which will require duplication of physical health services and facilities.

With reference to his other points, Cleere believes that they are, in fact, the cause of the last. These failures, he says, are the major reason the nation is faced with the issue of socialized medicine or national health insurance. The greatest buffer "against government encroachment in the private practice of medicine is a well-organized and well-staffed local health department, responsive to the public." "Responsive" would seem to encompass "comprehensive." However, current demands will not permit continuation of traditional public health practice. Direct, personal health care services must become part of the total, community health program and local health departments must accept the broader responsibility and enter the mainstream of the health care delivery system.[6]

Freedman believes that we should have foreseen the eclipse of our health departments as early as 1929, because of our consistent failure to respond to what we knew were the pressing health needs. He, like Cleere, assigns much the same reasons for failure but, in addition, maintains there is inability of public health physicians to rally community forces because of inceptness as leaders, politicians or social forces, "bound by law and status quo superiors."[7]

The appearance of the free-clinic movement of the 1960's is ascribed to this background. Based on the "now" philosophy, the "medical crisis" is blamed on the failure of "market-place medicine" to meet the wishes of the people. Sometimes derogated as "do-it-yourself clinics" or "storefront medicine" the guiding principle is that of consumer directed need or a health care program for peoples' sake, not for the sake of profits. The emphatic position that the present health care delivery system is a failure and that the community served must have the controlling interest in planning, organizing and administering such a system has overtones in the federal programs of the 1960's.[8]

The wave of reorganization shaking so many state health departments reflects the general dissatisfaction and points up the power struggles of various groups and disciplines to control the new force. The Regional Medical Program (RMP), in attempting to extend intramural medicine into the field, undoubtedly has strengthened the concept of a hospital dominated health care delivery system. With the heads of such institutions, often non-medical, regulating and grading degrees of care of facilities and referral patterns of patients, it is not altogether surprising to read that "since physicians have never quite understood the need for planning or sharing their domain with others, it seems reasonable to assume that community planning and consumer component will stand a better chance for survival with corporate structure managed by voluntary hospitals."[9]

This concept is not new. A regional hospital system was one of the major features of the Hill-Burton hospital construction act of 1946. However, as Terris says, it like every other federal program has failed. Despite spending seven per cent of the gross national product (GNP) for health services, significant portions of the population fail to receive adequate care. We attempt to solve health problems of the 20th century with social machinery of the 19th. The health crisis is not to be solved or alleviated by the timely institution of a few, well-chosen federal grant programs.

The health system, whether private hospital (inpatient) or private physician (outpatient) based is geared to the market system and affluent areas garner the most of both. Too, the American system does not restrict specialization and its increase reduces the effective ratio of primary care physicians to patients.[10]

Health surveys repeatedly reveal identified service needs chiefly in the area of provision of medical care. Strangely, planners express little recognition for the needs of health promotion, preventive or environmental protective services in other than remote rural areas. Divergence of opinion as to what

the health system should be is characteristic. Ingraham believes that planning is being conducted in an atmosphere in which the skills and motives of professionals are suspect and the consumer is being placed on a pedestal.[11] Others feel that planning is failing for lack of national purpose and commitment to a health policy and cite, as examples, Comprehensive Health Planning (CHP) and RMP.[13]

With such a variety of expertise, the call must come to cut through planning and get to the process. Yordy declares that social commitment is more important than structure; the major viewpoints are concerned with the nature of the national (governmental) role, not whether it should exist. Planning cannot substitute for the political process and social values are expressed through it.[12]

Most observers agree that a national commitment of some degree will be made within the foreseeable future.[14] A number of proposals have been advanced, agreeing for the most part on five general problem areas. The current administration's analysis is illustrative:

1. rapid inflation of medical costs;
2. maldistribution of manpower;
3. uneven quality of care;
4. inadequate emphasis on preventive health problems; and
5. financial barriers to medical care.[12]

It should follow that general goals in each plan would be much the same, and they are; but partisan approaches keep agreement and achievement far apart. As Seidman observes, none are really comprehensive or equal in access; do not restructure the health system; and, do not provide effective incentives for quality, efficiency or cost control. The most revealing point is that any plan should build on the principle of the National Health Security Bill which, for the first time, made the *right* of quality health care for all a realistic goal for national, state and local health planning.[13]

Conely believes that "right to health" has been the major impediment to a national health program. He cites work to show that right to medical care and opportunity to achieve it do not mean the same thing to all people. "Right" is first mentioned in the Congressional Record of 1796 and Franklin D. Roosevelt established it in his Economic Bill of Rights in 1946. However, AMA has had a restricted concept since the '20's.[14] Though it revised its intransigent attitude after losing the Medicare fight, AMA still sees "right to health" as applying to prevention in communities and groups and to the care of indigents but not to curative medicine for the individual. In today's usage, "right to health" *does* include prevention as well as curative medicine for the individual and, according to Kissick, the federal government has moved in this direction since 1935, beginning with the categorical grant-in-aid and continuing into the present "period of transition" dating from 1967.[17]

The second hindrance to a national health program is that health is not accepted as a social responsibility by individuals, federal government or corporate structure.[15] Rogers advocates creation of a separate department, directly responsible to the President, in order to bring to the formulation of health policy the degree of attention and emphasis needed to resolve the fundamental problems. The primary issue is to develop a framework on which to:

1. build a rational system for delivery of comprehensive health care, at nominal cost, with emphasis on prevention; and
2. develop new structures for national progress in education, solution of categorical disease problems and support of underlying scientific work in medicine and health.[18]

It should be abundantly evident that the storied state health department system of the Shattuck report is, today, over 100 years later, not only under attack but considered largely ineffective for delivery of a comprehensive health program. Yet, there is no better organizational framework available. Perhaps this is the reason for the advent of so many dual systems, attempting to parallel and supersede the established health system.

Most observers agree that a single system in health planning is essential. The current dual systems are admitted failures and could have been predicted. Look at the separate approaches in hospital and housing authorities. Conely asks how we can afford to talk about delivery of health care and not about the home and environment. It is not only useless; it is wasteful.

Similarly, delivery of a uniform, high standard of comprehensive care cannot be done immediately. A national minimum standard will be necessary, with a surveillance and review system providing for upgrading as intermediate goals are attained.[15]

To undergird the system, a program for scientific progress is essential. Terris comments that current

errors in delivery are correctible. Not correctible and inescapable are:

1. use of more complex technology, more highly trained and specialized personnel; and
2. increasing prevalence of chronic (*ergo,* more expensive) diseases in an aging population.

Thus, health care will continue to require a greater proportion of the nation's personnel and physical resources.[10]

Most of what physicians do still falls in what Thomas calls the non-technology area of supportive therapy. This requires continuation of the spectrum of graded care together with regionalization and health maintenance group concept. This, plus the half-technology area of medicine can bankrupt any health system unless the policy makers provide the research mechanism to develop real technology. "Our science is of the biological revolution and we have scarcely begun to apply any of it. Our lack of information about disease mechanisms cannot continue. Our time for the application of science in medicine is approaching and we will be forced to select alternatives in technology; make long range predictions; and, in short, practice technology assessment like any other great national enterprise."[19]

Here, poised on the brink of the 21st century, the epitome of modernity, we are constrained to concede that the "modern era" in public health is somewhere in the future. Despite general acceptance of government in health care delivery, there is no real concession to an expanded role for public health. Consequently, "public health professionals like everyone else are idly watching, fretting and wondering what will happen next."[16] Health departments, as we know them, cannot survive past patterns of performance. "What we are operating as public health programs, today appear, because of what we omit, as anachronisms."[7]

Public health professionals must develop a sense of mission and of means. They must form concepts of goals and standards for achieving them and, in short, get busy to help create the climate in which they must function. They must be willing to take the risks inherent in leadership roles and enter the lists at all levels of discussion, planning, legislative and administrative effort. They must sense and shape the things to come.

In terms of mission, we need something akin to what Thomas calls "dogma of faith." In essence, this says that disease and death do not equate; that, ultimately, a disease free society is possible so that most, if not all, should be able to die in reasonably good health. "Overpopulation is not produced by medicine; while it may alter slightly the number living at any one time, its real capability is to change, greatly, the quality of life."[19]

If we accept a disease free society as our ultimate goal, then mechanisms become important. Certainly, a strong basic research system must be advocated and supported; and for uniformity, a national policy and program agency is essential. But for the application of attained technology, the public health professional must realize that there is no better structure than a well-organized local health department system. Upon this framework may be placed a program of whatever degree of complexity or completeness may be desired in order to achieve national, state and local health goals. Whether it is used or not depends on the efforts we, as health professionals, expend.

Commenting on the development of a national health system, Brotherston supposes that the health system will use its planning capacity, including all resources, to strengthen the service as a whole and to achieve a balance so that each part of the system supports the others. There will be regard for all physicians, as a group, and not as belonging to separate species because of traditional labels as specialists, general practitioners or public health officers.[20] What this seems to say is that if the hierarchy is accepted, then its skeleton may be fleshed.

What all this means for public health is that the opportunity to come of age is at hand. There is, elsewhere, no greater concentration of expertise on health care delivery systems; in establishing goals and standards; in surveillance, evaluation and review mechanisms; and in systems development, application and operation. To stand by inactive and silent would be failing ourselves, our profession and our patients; individually and collectively, the public.

We, as public health professionals, may know our mission but we need to broaden our concept for application of our basic functions. These may be restated as:

1. collection, tabulation and analysis of vital, morbidity and mortality data;
2. ranking of the adverse diseases and conditions;
3. determination of their several etiologies;
4. postulating and testing methods for control; and
5. reporting new information for general use as soon as possible.

Critical evaluation reveals that none of this is prac-

ticable without the capability to see patients and, in fact, operate a clinical service. Even though such services were designed for "programs," patients have always appeared who did not fit the "program." This, combined with our knowledge of high risk populations, may help to explain the widespread misconception of public health as a service for "charity" or "indigent" patients. There is a second consideration, equally valid; namely, lack of appreciation that all medical service can be allocated into "levels of prevention" as taught by Leavell and Clark. These are:

1. health promotion (personal knowledge, practices and hygiene; control of environment; food and drug control, occupational safety, etc.);
2. specific protection (vaccines, essential nutrients, genetics, etc.);
3. early diagnosis and prompt treatment;
4. disability limitation; and
5. rehabilitation.[21]

Public health professionals should have no difficulty in accepting the thesis that a community health program has three facets:

1. personal health services;
2. environmental protection; and
3. health related social conditions.

We must structure our thinking to encompass the belief that any health system "with emphasis on prevention" must be geared to finding the patient before he is aware that he needs finding; that, in any case, prevention is instituted at as early a "level" as possible. In essence, the one hangs with the other and this is the substance of most proposals for meeting the health care "crisis." The future role of the public health agency lies in full assumption of its traditionally accepted mission and, for the first time, full utilization of applicable techniques. We must promote the soundness of "the Public Health Method" in this time of transition. We need not dwell on correction of past problems and failures. The future development of corollary and paramedical technologies will enable almost instant communication and information exchange if each part of the system does support the others.

The entire future of medicine does not hang on what public health does or does not do. Rather, the success of a community health program hangs on the degrce of application of the public health method. By whatever name it goes, the procedures will be the same and an agency can be found to apply them. The question is not "whether" or even "when." The crisis is of rising expectations and is "now," at least for the time of beginning again. We must not and will not be found wanting in meeting the challenge. An aging population, one of old, sick people, is an impossible thought for public health a century from now.[19] ★★★

State Board of Health (39205)

REFERENCES

1. Rumsey, Clark H.: Stephen Smith, M.D. N. Y. State J. Med. 72:21, pp. 2681-86, November 1, 1972.
2. Shattuck, Lemuel: Report of the Sanitary Commission of Massachusetts, 1850. Cambridge, Harvard University Press. 1948.
3. Wilson, C. E. A.: Foreword, *Ibid.*
4. Barker, Mary Louise: Who Represents the Patient? Am. Med. News 16:5, p. 2, February 5, 1973.
5. Sammons, James H.: The Physician's Responsibility to the Profession. Am. Med. News 16:5, p. 2, February 5, 1973.
6. Cleere, Roy L.: Health Departments: Quo Vadis? Tex. Med. 68:12, p. 67, December, 1972.
7. Freedman, Ben: What Is and What Must Be Done. A.J.P.H. 62:6, June, 1972.
8. Turner, Irene R.: Free Health Centers, A New Concept? A.J.P.H. 62:10, October, 1972.
9. Brown, Douglas R.: Community Health Planning, or Who Will Control the Health Care System. A.J.P.H. 62:10, October, 1972.
10. Terris, Milton: The Need for a National Health Program. Bull. N. Y. Acad. Med. 48:1, January, 1972.
11. Ingraham, Hollis S.: National Health Planning: Structure and Goals. Bull. N. Y. Acad. Med. 48:1, January, 1972.
12. Yordy, Karl D.: National Planning for Health: An Emerging Reality. Bull. N. Y. Acad. Med. 48:1, January, 1972.
13. Seidman, Bert: National Planning for Health: Structure and Goals. Bull. N. Y. Acad. Med. 48:1, January, 1972.
14. Hoffman, C. A.: Support for AMA's Position. Amer. Med. News 16:6, February 12, 1973.
15. Conely, Paul B.: National Planning for Health: Structure and Goals. Bull. N. Y. Acad. Med. 48:1, January, 1972.
16. Chapman, C. H. and Talmadge, J. M.: The Evolution of the Right to Health Concept in the United States. Pharos 34:30-52, 1971.
17. Kissick, W. L.: Health Policy Direction for the 1970's. New Eng. J. Med. 282:1343-54, 1970.
18. Rogers, Paul G.: The New Health. Bull. N. Y. Acad. Med. 48:10, November, 1972.
19. Thomas, Lewis: Guessing and Knowing: Reflections on the Science and Technology of Medicine. Sat. Rev. of Science 55:52, January, 1973.
20. Brotherston, John H. F.: Trends in the British National Health Service. Bull. N. Y. Acad. Med. 48:1, January, 1972.
21. Leavell, H. R. and Clark, E. G.: Preventive Medicine for the Doctor in His Community. New York, McGraw-Hill Book Co., 1958.

Problems, Needs and Preparation of Nurses in Nursing Homes in Mississippi

GEORGE J. TAYLOR, III, M.D.
Jackson, Mississippi

THIS COMMITTEE representing the MNA and the MSMA should be a potent force if it will follow through and see that all of its ideas are extended to the doctors and nurses involved in nursing home patient care across the state. This committee could set the standards for geriatric care in Mississippi.

First, I would like to tell you a bit of my philosophy relating to my job as physician member of the Mississippi Medicaid Commission's Medical Review Team for nursing homes. The primary purpose of periodic medical review is to promote higher quality medical management for nursing home patients; to stimulate greater institution responses to the physician's plan of care; to bring about a heightened interest and heightened consciousness among the physicians regarding their nursing home patients. The nurse members of our periodic medical review team serve as an excellent peer review for the nursing home's nurses but unfortunately, the review team does not function as a peer review for participating physicians. In fact, the nursing home is still not considered a place for medical practice by a large percentage of our physicians and even some of the best are relaxed in the care they provide the nursing home patients. This leaves a lot to be desired and it certainly affects the character of the nursing home. The medical review section of Public Law known as H.R. 1 was written in such a way that its authors hoped would cause doctors to become more active in their practice with nursing home patients and have a sort of built-in peer review. So far, this is not true. I do see improvement in some areas.

Next, in our review, while working with the nursing home nurse and administrator, it is emphasized that this is a nursing home, not a doctors home, where medical care is provided by nurses under a treatment plan provided and supervised by a physician. The nursing home's director of nurses is the key to the overall operation—she is the catalyst. If she is a good one, the nursing home usually is a good one. The records are in order and reflect the good care the patients are receiving. She knows of the doctor's reluctance to do paper work and is so organized that everything is made ready when he comes to visit, and his supervision in the overall treatment plan is reflected in the patient's record. This makes it easier for the nursing staff to follow. If the nurse is not motivated to doing her job, it shows in every phase of the nursing home's performance.

It seems unfortunate that the more training a nurse has, the farther away from the patient she becomes. Therefore, expertise in management is required. The nurse has to be organized in order that she may have more time with her patients. This is particularly true in our Mississippi nursing homes since there is usually only one R.N. present in each of them. She is a part of management and yet, she must be willing to work shoulder to shoulder with all members of her staff. She must be involved in all areas of patient care while providing continuing training and education for all of her personnel. Not only does she have to keep herself motivated, she has to keep all of the people working with her motivated. In other words she has to be familiar with personnel management problems.

Of singular utmost importance, nursing in nursing homes is altogether different from nursing in a hospital. It requires an altogether different set of attitudes; attitude toward old and infirmed people; attitude toward rehabilitation as much as possible for each old patient; attitude toward helping the old person to live rather than to die; attitude toward

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Presented before the Joint Practice Committee of the Mississippi Nurses' Association and the Mississippi State Medical Association, Jackson, Dec. 5, 1973.
Medical Consultant, Mississippi Medicaid Commission.

dying because the greatest route for attrition in the nursing home census is through death.

Specific problems facing the nurse in nursing homes are:

1. Thc patient himself and all that goes with the process of aging.
2. Adequate number of trained professionals to serve this typc constituent.
3. The problem of getting the physician "tuned in" to his nursing home medical practice. This possibly is the greatest obstacle we face at the present time. Getting his input into the care of these patients is important. The *nurse needs his supervision and his support.* Nurses have been criticized for prescribing without the doctor's order. In many instances she doesn't have a doctor or, if she has one she is afraid she will run him away or make him angry if she calls. In one home of note with a capacity census, there was an average of eight medications prescribed to be taken on a regular basis. The doctor's orders were up to date and signed; the progress notes, writtcn by the nurse, were also up to date and signed by the doctor. It was sad, however, to learn that a large percentage of the patients had not been seen by their doctor in over five months.

SPECIFIC NEEDS

Specific needs for nurses in nursing homes are:

1. Nurses *need* to know how to organize their day in order to have time to do their clerical work and also to have adcquate time to spend with the individual patient. She must have the know-how to cut corners and streamline paperwork and produce a clinical record that will describe the patient as he is.
2. She must realize the nursing home is the patient's home and the *need* to reduce the clinical atmosphere is great.
3. The *need* to fulfill the social, religious and recreational needs of the patients is a must if there is any hope for rehabilitation, or, if we want the older person to spend the remainder of his days living rather than dying. Each patient should be involved as much as possible in the plan of the day.
4. The need to know when and how to ask doctors to reduce medications. Really, she needs to know what she can do to more effcctively help the physician in fulfilling his responsibility to the patient and to the nursing home.
5. The *need* to continually train all of her staff in the problems of the aging process and how to cope with them; keeping them aware of the so-called nursing failures such as immobilization, catheters and decubiti; helping her staff to maintain a working knowledge of reality orientation, bowel and bladder training and motivation of patients.

NURSING STANDARDS

Preparation of nurses:

The Standards for Geriatric Nursing Practice of the American Nursing Association offers an excellent outline for the nurse to work on in preparing herself for this type of career:

1. The nurse demonstrates an appreciation of the heritage, values, and wisdom of older persons.
2. The nurse seeks to resolve her conflicting attitudes regarding aging, death, and dependency so that she can assist older persons, and their relatives, to maintain life with dignity and comfort until death ensues.
3. The nurse observes and interprets minimal as well as gross signs and symptoms associated with both normal aging and pathologic changes and institutes appropriate nursing measures.
4. The nurse differentiates between pathologic social behavior and the usual life style of each aged individual.
5. The nurse supports and promotes normal physiologic functioning of the older person.
6. The nurse protects aged persons from injury, infection, and excessive stress and supports them through the multiplicity of stressful experience to which they are subjected.
7. The nurse employs a variety of methods to promote effective communications and social interaction of aged persons with individuals, family and other groups.
8. The nurse together with the older person designs, changes, or adapts the physical and psychosocial environment to meet his needs within the limitations imposed by the situation.
9. The nurse assists older persons to obtain and utilize devices which help them attain a higher level of function and ensures that these devices are kept in good working order by the appropriate persons or agencies.

After the nurse has started in this career, she should attend every workshop and interest group related to geriatric nursing that she can. This continued education keeps her motivated.

In most of our Mississippi nursing homes the physical needs of the patients are met but in many instances the emotional and other needs are overlooked. I agree with one of the nurses I work with who stated, "I think that before a nurse can really be an effective geriatric nurse she must analyze how she personally feels about the older person. They must feel loved and needed. They must be allowed to remain the person they have been for all of the past years. The nurse must respect the older person as an individual and realize that the patient can enrich her life."

Possibly physicians look upon the nursing home patient as a patient at home who requires medical care that someone at home needs. This is not the case. Physicians need to see the geriatric patient in the same light as stated above by the nurse—as it really is. The growing problems of health care for the aged, with myriad tentacles and consequences, are upon us. They will not go away by putting our heads into the sand or wishing it so. The problems will be solved only when everyone's input has been added and maintained on a continuing basis. ★★★

2906 North State Street (39216)

NOT WHEN, BUT IF

Their 20th anniversary was approaching, and the husband went to the store where his wife always shopped. There he began looking around for a present. "How about some really nice perfume?" the sales clerk suggested. Spraying some on him, she said, "This scent is called 'Say When.' "

"Lady," he told her, "We've been married 20 years. 'Say When' smells good. But I wonder if you have any called 'Say If'!"

Radiologic Seminar CXXXVI: Linitis Plastica: "Leather-Bottle Stomach"

CLYDE R. ALLEN, JR., M.D.
Laurel, Mississippi

CARCINOMA may spread submucosally in the stomach, leaving the mucosa intact, creating what has been called linitis plastica or "leather-bottle stomach." This scirrhus carcinoma is characterized by its infiltrating nature and its ability to invoke a pronounced fibrous tissue response in the gastric wall. Linitis plastica constitutes about 5 per cent of gastric carcinomas.

The most striking feature of linitis plastica is diminution in size of the stomach usually tapering rapidly from fundus to pylorus. Typical radiographic

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jones County Community Hospital, Laurel, Miss.





Figures 1 and 2. Note the unchanging contour and absent peristaltic waves. Persistent irregularities are present along the greater curvature and at the incisure.



Figure 3. Reduced gastric size especially in the antrum is noted, and the absent peristalsis and abnormal mucosal pattern is apparent.

signs of the more common fungating carcinoma such as "thumb-printing," nodularity, ulceration and sharp transition from normal to abnormal are not present.

In addition to reduction in size, peristalsis is diminished or absent, and the stomach does not distend due to the sclerosing growth. The contour of the stomach may, in some instances, show minor irregularities which persist on multiple films in all projections. Usually both the esophago-gastric junction and the pylorus are widely patent, and the esophagus may dilate due to the decreased gastric capacity. Scirrhus carcinoma may involve the entire stomach in linitis plastica or may be more localized. Occasionally, the thickened wall of the stomach can be outlined between its barium-filled lumen and air in adjacent colon.

Although seldom seen, the typical appearance described above has been reported in cases of tertiary syphilis. Other differentials would include: lymphoma, corrosive gastritis, granulomatous diseases, pyogenic gastritis and regional enteritis. ★★★

1220 Jefferson Street (39440)

REFERENCES

1. A Textbook of X-Ray Diagnosis, Vol. IV, Shanks and Kerley, Philadelphia, W. B. Saunders Co., 1969.
2. Gastroenterology, Bockus, Philadelphia, W. B. Saunders, 1963.
3. Radiology of the Digestive System, Lumsden and Truelove, Philadelphia, F. A. Davis Co., 1965.

The students were demonstrating, and a policeman walked up to one boy and asked, "Do you go to this college?" He said, "No." "Do you belong to a political party?" "No." "Do you go to *any* college?" "No." "Do you have a job?" Again the answer was, "No." "Well, what are you protesting?" He said, "Noninvolvement!"



The President Speaking

"Opinions on the Legislative Scene"

ARTHUR A. DERRICK, JR., M.D.
Durant, Mississippi

HAVING JUST served my yearly stint as Doctor of the Day at the capitol, the following thoughts concerning our profession's legislative apathy come easily to mind.

I realize that many of us not only lack interest in the machinations of the political arena, but that some of us may even harbor an inborn positive aversion to such carryings-on, so foreign to our circumscribed world of the ill and the not-so-ill. We must also realize that the welfare of our patients and ourselves may be strongly affected by the legislation produced there in what may appear at first sight as a disorganized scramble for votes to pass pet issues. I feel certain that many of our long-accepted procedures, clear enough to us, might give them pause—such as a thick hospital chart or a stack of scarcely decipherable prescriptions!

MSMA has made and is making a definite effort with the blue sheet and the EMCU to cross this chasm that divides us. The medically-oriented bills before both house and senate each session deserve, (no, demand) our interest and attention. As one legislator put it—they need to know how we feel *before* a bill is brought up, and not a wondering "why did you pass this" after the fact. There is no doubt in anyone's mind that the most forceful and effective way to express the opinion of the profession is in personal man-to-man contact between the solon and his personal physician. If he will make the effort to keep himself informed and available, he will do his patients, himself and his association a great service. ★★★

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EDITORIALS

High Blood Pressure: As a Physician Sees It

We do not know the cause of the common, garden variety of hypertension, which makes up about 90 per cent of high blood pressure. We have no knowledge as to why it starts in an individual. There have been a lot of theories, such as the theory of familial trait, the idea of excessive nervous system stimulation, and so forth. We actually don't know what hypertension is. Sir George Pickering, a well-known British physician, when asked how he would define hypertension, said that he wouldn't. He said, "We don't really know what it is. Just call it high blood pressure." Anyhow, the word is common in use.

When the average person comes into the doctor's office with hypertension, we begin to think in certain areas. First, we like to know the age of the patient, in addition to usual data—name, height, and weight. If this person is over 35 years of age, we now feel it is not necessary to go into an elaborate diagnostic workup regarding his blood pressure. This is somewhat contrary to the old feeling. We were taught that when a patient appeared with hypertension, he should be put through all the workup—including x-rays and extensive laboratory studies. However, the cost of an elaborate examination along this line would run into hundreds of dollars. We feel this expense is not justified. We have found through the years that most people who have gone through these studies, and are over the age of 35 or so, really have shown nothing that has helped us in the way of diagnostic findings. In other words, these people have the regular type of hypertension called essential hypertension.

A person under 35 years of age with high blood pressure is a different story. We feel that these individuals should be afforded certain special diagnostic studies. The young individuals will sometimes have the smaller 10 per cent form of hypertension, referred to as secondary hypertension. In other words, the high blood pressure is secondary to something else being wrong in the body.

There are certain things we think about in young individuals with high blood pressure. One is a congenital condition, which is called coarctation of the aorta. This is a narrowing of the main artery that takes the blood from the left side of the heart, and because of the constriction or partial blockage of the main artery, the blood pressure will be elevated. This is usually recognizable on physical examination alone and is usually detected at a fairly early age. It can be cured. That is the nice part about so-called secondary hypertensions. Most can be cured if they are found early enough.

Another form of secondary hypertension that we look for is in the kidney—particularly the renal arterial supply. There are certain changes occurring in the renal arteries that can produce hypertension. A form of thickening and irregularity of these arteries occurs often in young women, producing high blood pressure. There are also changes that sometimes occur in young individuals in a process of

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Presented to the 1973 Mississippi Heart Association Annual Assembly. Dr. Tatum is immediate past president of Mississippi Heart Association.

thickening due to a form of atherosclerosis. These conditions likewise may be surgically treated and the hypertension cured.

There are certain tumors of the adrenal gland which produce hypertension. There is a tumor of the middle part of the gland that produces too much adrenalin and a tumor of the outer part of the gland which forms too much of the hormone called aldosterone. These will also produce hypertension. Thus, in any young individual with high blood pressure, we look for all these things, and some of the diagnostic studies are very elaborate. But the other person, particularly the one over 35, doesn't require a great deal of workup and diagnostic study before treatment is begun. We are fortunate to have a large number of effective drugs which can be used to control hypertension in this person.

Hypertension is sometimes spoken of as the "Silent Disease." The reason is that there is no way that anyone can tell whether or not he has hypertension until he has his blood pressure measured. I'm sure you've known individuals who have hypertension, and you've heard them say, "I know my blood pressure is up today because I have a headache and I feel a little dizzy." I can assure you this is not true, because high blood pressure does not produce symptoms. It is completely asymptomatic.

Probably where the misunderstanding comes is that we all have a blood pressure which fluctuates according to the degree of our emotional stress and tension. Anxiety and tension may produce a headache. Anxiety and tension may also produce elevation of blood pressure. A person who is anxious and tense quite often comes into the doctor's office and says, "Doctor, I know my blood pressure is up because I have a headache." Actually, he had a headache because he's nervous and tense, and his blood pressure is up because he's nervous and tense. Likewise, hypertension does not cause dizziness and other symptoms. This is a common misunderstanding and one that needs to be clarified.

There are certain forms of hypertension, which we now see rarely, called malignant hypertension and hypertension secondary to chronic renal disease other than those previously mentioned. Symptoms sometimes do occur in these uncommon forms, but they are in the rare minority. Therefore, for all practical purposes we can say essential hypertension is a silent disease and one that produces no symptoms.

This is why our high blood pressure detection program is so important. We must find the person with high blood pressure who doesn't come to the doctor because he has no symptoms. Once it's established that the person does have hypertension, by appropriate diet (a diet that's low in sodium content) and appropriate drugs, we can control his blood pressure. Many people have slight elevation of their blood pressure purely because they carry around excessive weight. Often all these people need to do is reduce their weight and their blood pressure will return to normal.

FREDERICK E. TATUM, M.D.
Hattiesburg, Miss.

History of the Hippocratic Oath

Hippocrates was born around 460 B.C. and is known as the father of modern medicine. Even though his principles of medical science were laid down 400 years before the birth of Christ, they were the basis of the medical theory which was developed in the 1800's.

Graduating medical students still take the Hippocratic Oath which reads:

> I do solemnly swear by that which I hold most sacred: That I will be loyal to the profession of



"Mike begins his practice next week."

medicine and just and generous to its members;

That I will lead my life and practice my art in uprightness and honor;

That into whatsoever house I shall enter, it shall be for the good of the sick to the utmost of my power, I holding myself aloof from wrong, from corruption, from the tempting of others to vice;

That I will exercise my art solely for the cure of my patients, and will give no drug, perform no operation, for a criminal purpose even if solicited, far less suggest it;

That whatsoever I shall see or hear of the lives of men which is not fitting to be spoken, I will keep inviolably secret;

These things do I promise and in proportion as I am faithful to this oath, may happiness and good repute be ever mine—the opposite if I shall be forsworn.

Hippocrates, you might gather from this oath, was a pleasant combination of the idealist and the realist. In a time when superstition ruled men's minds, Hippocrates believed only in facts. Before Hippocrates, medicine had been in the hands of the priests (of the god of medicine—Aesculapius). He showed that disease had only natural causes, and he took treatment of disease out of the hands of religion. Hippocrates insisted that "Nature heals, the physician is only nature's assistant." He applied this rule by treating his patients with proper diet, fresh air, change of climate, and attention to habits and living conditions. He objected to the use of strong drugs without careful tests of their curative values. He applied logic and reason to medicine and made it workable.

In the oath that appears above, Hippocrates gave the medical profession a sense of duty to mankind which it has never lost. The oath is perhaps more pertinent today than ever before. Today's second year medical student is equipped with more available knowledge than the practicing physician of 30 years ago. With this increasing knowledge goes an equal amount of responsibility. New technological advancements bring new problems which must be weighed by today's physician. The availability of new procedures in heart and kidney transplantation leads to hair-splitting decisions in ascertaining the legal as well as moral aspect of donor life or death. Modern facilities which provide intensive care units add still more problems to the long list of physician responsibilities in that often the decision to prolong life indefinitely is left up to the attending physician rather than the family even though the patient is solely maintained by external mechanical devices. Many of these technological advancements with their subsequent moralistic decisions were simply unheard of 30 years ago. The problem of ascertaining life vs death was relatively uncomplicated at that time. With the advent of newer and better systems of patient management, the Hippocratic Oath has become not just a building block in formulating the total makeup of today's physician, but a firm foundation on which every new addition is placed in establishing a professional entity.

RALPH VANCE, M.D.
Medicine Resident
University Hospital, Jackson, Miss.

(Was first presented on "Coffee With Judy" (Channel 3, WLBT) at the regularly scheduled University Medical Center time on Wednesday)

Chances of Being Injured by Medical Malpractice? They're Very, Very Small

Despite the publicity resulting from a few large malpractice cases, a medical malpractice incident is a relatively rare event; claims are even rarer and jury trials are rarer still.

- In 1970, a malpractice incident was alleged or reported for one out of every 158,000 patient visits to doctors.
- In 1970, a claim was asserted for one out of every 226,000 patient visits to doctors.
- Fewer than one court trial was held for every 10 claims closed in 1970.
- Most doctors have never had a medical malpractice suit filed against them and those who have, have rarely been sued more than once.
- In 1970, 6.5 medical malpractice claim files were opened for every 100 active practitioners.
- A 10-year survey, from 1960 to 1970, of the claims experience of 2,045 physicians in Maryland indicated that 84 per cent had not been sued, 14 per cent were sued once, and 2 per cent were sued more than once.
- Most hospitals, no matter how large, go through an entire year without having a single claim filed against them.

- Sixty-nine per cent of 4,113 hospitals surveyed from June 1971 to June 1972 had not had a malpractice claim, 10 per cent had one, and 21 per cent had two or more.
- Most patients have never suffered a medical injury due to malpractice and fewer still have made a claim alleging malpractice.
- If the average person lives 70 years, he will have, based on 1970 data, approximately 400 contacts as a patient with doctors and dentists. The chances that he will assert a medical malpractice claim are one in 39,500.—*AMA Update,* Vol. 3, No. 5, Nov. 1973



THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Feb. 4-8, 1974

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Feb. 4-8, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

W. Lamar Weems, M.D., associate professor of surgery (urology), The University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

Feb. 11-15, 1974

PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson
Feb. 11-15, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

J. M. Montalvo, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Registrants will participate in intake and ward rounds and refresh their skills in such areas as scalp vein techniques, use of the respirator, resuscitator, nebulizer and humidifier. Lectures and round table discussions will take up common pediatric problems such as immunizations, allergies, pediatric emergencies, pediatric surgery and care of the newborn.

Feb. 18-22, 1974

OTOLARYNGOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Feb. 18-22, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Godfrey E. Arnold, M.D., professor of surgery (otolaryngology) and director of the Division of Otolaryngology, The University of Mississippi School of Medicine

At least 30 per cent of family medicine is concerned with ear, nose, and throat diseases. This course will present the basic knowledge of otolaryngology as needed by the family physician, including office treatment and detection of complications. Lectures, seminars, clinics, rounds, demonstrations and surgical observations will take up audiology, vestibular testing, speech and voice rehabilitation, allergy clinic, and neurotology.

All the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

University Medical Center, Jackson
Feb. 4-8, 1974, and Mar. 18-22, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Alfred W. Brann, Jr., M.D., assistant professor of pediatrics and director, newborn center, The University of Mississippi School of Medicine

This course, presented in January and repeated in February, is planned for physician/nurse teams. Most of the content will be presented in

joint sessions, with ample time allowed for discussion of special problems in nurseries represented by the teams in attendance. It is open to physicians involved in the care of newborns as the primary physician. There is a $10.00 fee for physicians.

FUTURE CALENDAR

Feb. 4-8, 1974
UROLOGY INTENSIVE COURSE

Feb. 4-8
NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

Feb. 11-15
PEDIATRICS INTENSIVE COURSE

Feb. 18-22
OTOLARYNGOLOGY INTENSIVE COURSE

Mar. 4-8
CARDIOLOGY INTENSIVE COURSE

Mar. 14-16
SURGERY CONFERENCE

Mar. 18-22
NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

May 6-9
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

Nursing Home Regulations Amended

The Department of HEW has amended its regulations for upgrading care in skilled nursing facilities participating in Medicare and Medicaid programs. Included is a requirement for all such facilities to have a medical director or an organized medical staff responsible for and coordinating medical care services. A local medical society can furnish the latter.

Another major policy change in regulations for skilled nursing facilities calls for coverage by a registered nurse seven days per week at least on the daytime tour of duty.

Attending physicians are required to see their patients at least once every 30 days through the first three months after admission and at least once every 60 days thereafter.

Emphasis has also been placed on the need for strict compliance on the part of skilled nursing facilities to adhere to the Life Safety Code adopted by HEW in October 1971.

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Medico-Legal Brief

PHYSICIAN LIABILITY FOR HEALTH CARE ASSISTANTS

A new health occupation has been created by the California legislature. Called "health care assistant" or "physician's assistant," the new occupation is an attempt to infuse new manpower into the health care field and maintain the quality of care received by the patient. A law review article discussed the tort law doctrine of *respondeat superior* and how it presently would deter physicians' utilization of assistants.

The health care assistant program is designed to be implemented quickly. Only two years of special medical education are required, with a premium on experience. Former medical corpsmen, nurses, and technicians form a ready manpower pool. The author suggests that application of current tort law doctrines to the unique relationships between physicians, this new class of assistants, and patients would be unwise.

Two types of tort doctrines, liability of the assistant for his own negligence and liability of the physician for his negligent supervision, can have a beneficial impact on the program. A third type, liability of the physician for the torts of the assistant under the doctrine of *respondeat superior,* could greatly hinder the use of physicians' assistants, the author contends.

Following the traditional approach, the physician's assistant will probably be held to the standard of care of the ordinary assistant practicing under similar circumstances. This would result in slight reduction in the quality of care required by tort law, but it may be justified because to hold assistants to the standard of care of the ordinary physician would deter people from becoming assistants. Certification by the board of medical examiners and an effective educational policy are suggested as quality control mechanisms.

Proper enforcement of the assistant's duty to refer to physicians cases beyond his competence would promote proper care without weakening the assistant's usefulness.

The physician is obligated to use due care in the selection of this assistant. It is suggested that a physician be allowed to defend against a claim of negligent selection based on board approval of the assistant.

Negligent supervision of the assistant is another basis for liability, although it is rarely used today. It relates to the physician's own acts or omissions, not the assistant's.

Respondeat superior, the liability of a physician for the negligent acts of his assistants, is the legal theory which would be applied unless the legislature provides otherwise. Because of this potential liability and the general dread among physicians of a malpractice suit, the application of this theory would certainly deter physicians from using assistants, the author believes. The additional risks of malpractice suits for someone else's mistakes would seem to outweigh the increased productivity of a physician using an assistant.

Compensation of accident victims is the most important justification for *respondeat superior.* Traditionally, employers have more financial means than employees. However, there is no reason why physicians' assistants could not be required to carry their own adequate liability insurance, thus rendering unnecessary the *respondeat superior* doctrine.

The author concluded that *respondeat superior* posed a substantial threat to the success of the physicians' assistant program.—*Tort Liability and the California Health Care Assistant,* by Steven J. Burton, 45 Southern California Law Review, No. 3, p. 768 (1972).



ELLIS, CLYDE ALLEN, Clarksdale. Born Lambert, Miss., Mar. 25, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned Mississippi Baptist Hospital, one year; radiology residency, same, 1970-1973; elected by Clarksdale and Six Counties Medical Society.

RADER, BENJAMIN B., JR., Indianola. Born Pittsburgh, Penn., June 3, 1937; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned Mississippi Baptist Hospital, one year; psychiatry residency, same, one year; elected by Delta Medical Society.

ROBINSON, WILLIAM T., Clarksdale. Born Laurel, Miss., April 12, 1939; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1963; interned Chelsea Naval Hospital, Chelsea, Mass., one year; surgery residency, University of Mississippi School of Medicine, 1967-72; elected by Clarksdale and Six Counties Medical Society.

SMITH, N. E. MURILLO, Meridian. Born Honduras, Central America, Nov. 1, 1934; M.D., Mexico Na-

tional University, Mexico, 1963; interned General Hospital, Mexico D.F., one year; elected by East Mississippi Medical Society.

WEATHERALL, JAMES SPURGEON, JR., Moss Point. Born Jackson, Miss., Mar. 13, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned Wilford Hall USAF Hospital, San Antonio, Tex., one year; radiology residency, University Medical Center, Jackson, Miss., 1971-1973; elected by Singing River Medical Society.

DEATHS

KYLE, WILLIAM P., Biloxi. M.D., Meharry Medical College School of Medicine, Nashville, Tenn., 1903; interned Mercy Hospital, Nashville, Tenn., one year; died Dec. 24, 1973, age 96.

NOBLIN, W. E., JR., Jackson. M.D., Emory University School of Medicine, Atlanta, Ga., 1934; interned Charity Hospital, New Orleans, La., one year; died Dec. 27, 1973, age 67.

PERSONALS

JOEL ALVIS of Jackson is new president of Central Medical Society. J. W. AUSTIN of Forest is president-elect.

ROBERT H. BARNES, JR., of Natchez and Mrs. Barnes have been named Tulane Annual Fund chairmen for the Natchez area.

RICHARD C. BORONOW of UMC met recently with the editorial board of *Contemporary Ob-Gyn* in Milwaukee. He also attended a gynecologic-oncology group meeting in Phoenix along with CARL G. EVERS of UMC.

JOHN BOWER of UMC participated in a clinical dialysis and transplant forum sponsored by the National Kidney Foundation in Washington.

MAGRUDER S. CORBAN of Gulfport has been named State Representative of the Committee on Injuries of the American Academy of Orthopaedic Surgery.

JOHN EVANS of Tupelo was named "Physician of the Year" by the area Medical Assistants chapter during their annual Christmas party.

JOSEPH C. GRIFFING of Picayune has been named Tulane Annual Fund chairman for the Picayune area.

ARMIN HAERER of UMC attended a study group meeting in Indianapolis Dec. 14-15.

JAMES D. HARDY of UMC gave the presidential address at the Southern Surgical Association's annual assembly in Hot Springs, Va. Dr. Hardy spoke on "Medical and Surgical Education in the South."

B. T. HICKMAN of UMC attended a gynecologic-oncology group meeting in Scottsdale, Ariz.

JOHN F. JACKSON of UMC was recently presented the Harold Cummins Award in honor of Dr. Cummins, Tulane School of Medicine emeritus professor of anatomy.

JOE E. JOHNSTON of Mt. Olive is new president of the South Mississippi Medical Society. J. L. SMITH of Hattiesburg is secretary and TOM J. ANDERSON of Laurel is president-elect.

DEWEY LANE of Pascagoula is serving as chairman of the Mississippi Economic Council's Committee on Education.

ROBERT D. MCBROOM, III, of Pascagoula is new president of Singing River Medical Society. Other officers are: JEFF A. HODGES of Pascagoula, secretary; JAMES K. WILLIAMS, JR., of Pascagoula, delegate to MSMA; and WALLACE E. CALHOUN, JR., of Moss Point, alternate delegate.

J. M. MONTALVO of UMC addressed the Mid-South Pediatric Society in Memphis and spoke at grand rounds in the Department of Pediatrics at the University of Tennessee in December.

PAUL MOORE of Pascagoula is serving as 1973-74 president of the University of Mississippi Alumni Association.

JOE R. NORMAN of UMC was a recent guest speaker during medicine rounds at Southwestern Medical School in Dallas.

JAMES W. RAYNER of Oxford is president of the North Mississippi Medical Society. CHERIE FRIEDMAN of Oxford continues to serve as secretary.

R. A. ROBERTS of Moss Point has been appointed to his third consecutive five-year term as a member of the Mississippi Gulf Coast Junior College Board of Trustees, representing Jackson County District 2.

HARRY J. SCHMIDT, SR., of Biloxi has been named the city's Outstanding Citizen for 1973 by the Biloxi Lions Club. Dr. Schmidt was honored for his 40 years of medical practice and for his activities in preserving the heritage of the coast area.

ALVAH H. SINCLAIR-HALL of Gulfport has recently joined the medical staff of Gulfport Memorial Hospital as a surgical assistant.

FREDERICK E. TATUM of Hattiesburg has been appointed to the Central Committee for Medical and Community Programs of the American Heart Association. As a member of this committee, Dr. Tatum will represent the eight state Southern Region in coordinating the 14 individual scientific councils of AHA.

WALTER TAYLOR of Clarksdale was in charge of arrangements for a free screening clinic for hypertension held in Clarksdale Jan. 30 and sponsored by the Coahoma County Heart Association. Dr. Taylor is chairman of District 4 of the Mississippi Heart Association. Physicians and nurses voluntarily manned the clinic.

WILLIAM B. TUMLINSON of Jackson announces the relocation of his offices to 1421 North West Street.

JOHN W. WALLER of Monticello received the eagle insignia of colonel at recent ceremonies at the Capitol. Dr. Waller is Group Surgeon for the National Guard's 631st Artillery Group of Grenada.

RICHARD L. YELVERTON of Jackson announces the relocation of his office to Suite 310, St. Dominic Medical Offices, 971 Lakeland Drive. Dr. Yelverton's practice is limited to general and thoracic surgery.

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Book Review

Review of Physiological Chemistry. 14th Edition. By Harold A. Harper, Ph.D. 545 pages with illustrations. Los Altos, Calif.: Lange Medical Publications, 1973. $8.50.

The purpose of this book is well discussed by the author in the Preface which states:

"This review is intended to serve as a compendium of those aspects of chemistry that are fundamental to the study of biology and medicine. A prominent feature of its success since the 1st edition appeared in 1939 has been the opportunity afforded by frequent revisions to include recent contributions to the field. However, the accumulation of knowledge continues to pose the difficult problem of giving adequate attention to recent discoveries while still serving the original purpose of the review as a more concise source of information than the standard textbook. It is hoped that the current edition represents a reasonable solution to this problem and that those readers will continue to be served who seek to gain an introduction to the subject or who may desire a review such as is required in preparation for examinations for state and specialty boards.

"In the 14th edition, the review continues to reflect the substantial contributions of Drs. Gerold M. Grodsky, Peter A. Mayes, and Victor Rodwell as acknowledged in each of the chapters with which they are identified. Dr. Tawfik Elatter collaborated in the writing of the section on steroid hormones in chapter 20. The illustrations, including structural formulas and metabolic schemes, reflect the superb skill of Laurel V. Schaubart. Her contribution to the review is one of its most precious assets."

As a busy, practicing internist who has not seriously looked over a textbook in biochemistry in a number of years, I confess I had not the time nor the inclination to read this book of over 500 pages with thoroughness. Some of the chapters on metabolism of lipids, chemistry of the tissues, function of the hormones, etc., were certainly more up-to-date than I can recall from my medical school days, but basically it is a textbook for students and not quite what one would look for in immediate help in solving problems presented by our patients.

The discussion of function of vitamins went along the established medical thinking and certainly did nothing to support the wild claims from certain quarters for mega-vitamin therapy. The book may be useful to have on hand as a current reference book to occasionally reach for, but I would not advise the usual practitioner to rush out and buy a copy. As mentioned in the Preface, it should be a good review for preparation for board examinations.

Joe S. Covington, M.D.
Meridian, Miss.

SBH Announces Plans for Sanatorium

The Mississippi State Board of Health has announced plans to seek legislative authority to expand services offered at the Mississippi Sanatorium to include extended care services for selected patients with tuberculosis or other chest diseases and a detention unit for recalcitrant or disciplinary problem patients.

State Health Officer, Dr. Alton B. Cobb, announced the new plans for the sanatorium in accordance with a resolution adopted by the State Board of Health at its December meeting and sent to the Governor and members of the Mississippi Legislature. The future of the Mississippi Sanatorium has been a matter of concern to the Mississippi Legislature for the past several years. Proposals for its use have covered the gamut from complete closing to development of a cancer research center.

In its resolution the State Board of Health expressed its belief that there was a clear and continuing need for a state sanatorium for the care of patients with tuberculosis and other chest diseases and that adequate staffing for an augmented case load could be developed by improved facilities, effective recruitment, and pertinent liaison with other medical centers and institutions of higher learning.



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Unveiling of 50th year commemorative quilt

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See you there!

Jane Preston
(Mrs. William H. Preston, Jr.)
President, Woman's Auxiliary

50

MSMA Board of Trustees Holds Its Regular Winter Meeting

The MSMA Board of Trustees handled a full agenda of business at its Dec. 19-20, 1973, meeting in Jackson including approval of the association's 1974 budget, the annual review of the association's group insurance programs, reports from the Council on Legislation and Committees on Realignment of the Board of Trustees and Long Range Planning, and a meeting of the Mississippi Foundation for Medical Care Board of Directors.

The Board approved a 1974 budget of $227,996 for total MSMA funded operations based on recommendation from the Council on Budget and Finance. The Board also approved a recommended dues increase of $25 effective 1975 based on favorable action by the House of Delegates at the annual meeting in May. In considering the council's report along with a report from the Committee on Long Range Planning, both of which dealt with present and future income needs of the association, the Board directed that a study be made of new sources of income for the association in lieu of future large dues increases, particularly in regard to income producing services the association could offer its members at lower cost through a nonprofit business service corporation.

The Council on Legislation presented its first report reviewing the association's program for the 1974 Regular Session of the Mississippi Legislature noting therein that the association would support legislation to establish a statewide medical examiner's system, to remove limitations on insurance coverage of newborns, to provide an expanded role for registered nurses, to require a uniform claim form for



The MSMA Board of Trustees considered many items of importance during their winter meeting, Dec. 19-20, 1973, at the association headquarters building in Jackson.

physician services, and to provide a legal shelter for peer review. The Board also adopted a "Statement on Abortion" recommended by the Council on Legislation and directed that the association's General Counsel investigate and seek to prevent apparent violations of the Chiropractic Licensing Act by the State Board of Chiropractic Examiners.

The Board received for information only a report from the Committee on Realignment of the Board of Trustees dealing with reapportionment of trustee districts, terms of Board members, and the composition of the Board. The committee reported plans to recommend reapportioning the MSMA trustee districts so that 140-160 MSMA members would be represented by each Board member. The committee also reported that it would recommend to the House of Delegates that the president and immediate past president of the association be voting members of the Board and that terms of all Board members and members of elected councils be limited to two-three year terms instead of the present three-three year terms.

In other business the Board heard an annual report on the association's group insurance plans and noted that plans to upgrade and increase benefits under the current plans would be announced to all members. The Board also received a report from the association's AMA delegates in regard to the recent Clinical Meeting of the AMA House of Delegates and directed that the report be published in an early issue of the JOURNAL MSMA. The Board adopted a memorial resolution on behalf of Dr. Mal S. Riddell, Jr., and commended the State Board of Health and the Board's director, Dr. Alton B. Cobb, on the recent reorganization plan adopted by the State Board of Health.

On Dec. 20 the Board met with other directors and officers of the Mississippi Foundation for Medical Care. The MFMC Board acknowledged designation of Mississippi as a statewide PSRO area as recommended by the MFMC, and supported by the Mississippi Hospital Association and Mississippi State Board of Health. In this same connection, the Board received a report from its subcommittee on PSRO which reviewed the committee's work to date under an initial grant from the Mississippi Regional Medical Program for PSRO planning.

The MFMC Board also heard a report from its Committee to Study and Develop Professional Fee Schedules in which the committee noted that it had received a 70 per cent response to its survey of MFMC members and planned to conclude its present study with a meeting of all Mississippi Specialty Society officers in late January.

The MFMC Board adopted a report from its president, Dr. J. T. Davis, recommending that: (1) the MFMC proceed to develop a minimum standards contract covering both fees and benefit levels to be tested on a pilot basis with a carefully selected health insurance carrier after approval by the MFMC membership; (2) the MFMC proceed to offer the PSRO review mechanism, when evolved, to all health insurance carriers, at cost, as provided in Public Law 92-603; and (3) the MFMC Board be expanded to include at its next meeting those new directors previously authorized representing the insurance, business, nursing, and hospital professions, and labor, and that the new directors not participate in peer review activities of the foundation. The following MFMC officers were elected to serve during 1974: James O. Gilmore, M.D., Oxford, chairman; Gerald P. Gable, M.D., Hattiesburg, vice chairman; Everett H. Crawford, M.D., Tylertown, secretary; and J. T. Davis, M.D., Corinth, president.

Dr. Derrick Appointed Kidney Fund Trustee

Dr. Arthur A. Derrick, Jr. of Durant, MSMA president, has been appointed one of three trustees for the state kidney trust fund.

The $350,000 for the kidney trust fund represents the amount overpaid by individual citizens in the state for the antibiotic tetracycline.

The suit to recover the funds was begun in 1966 and continued through a federal court in New York until a settlement was reached with the two firms—American Cyanamid Co. and Charles Pfizer Co.

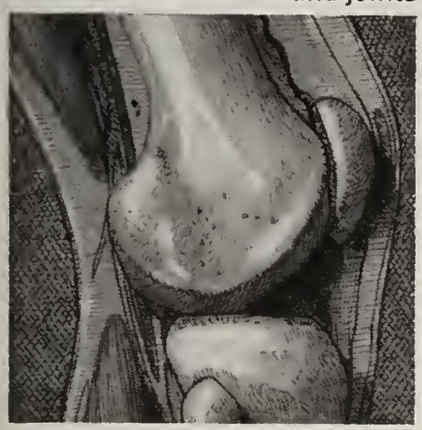
The two firms were accused of price fixing on tetracycline which the state charged was being sold at prices of 40 to 50 cents too high.

Over $750,000 of the refund will be distributed to 67 hospitals around the state while the remainder, $350,000, will be placed in a trust fund for supplies, equipment and research to be used in the treatment of kidney diseases.

Other trustees of the kidney fund are Atty. Gen. A. F. Summer and Joe Daniel of Jackson, president of the Mississippi Bar Association.

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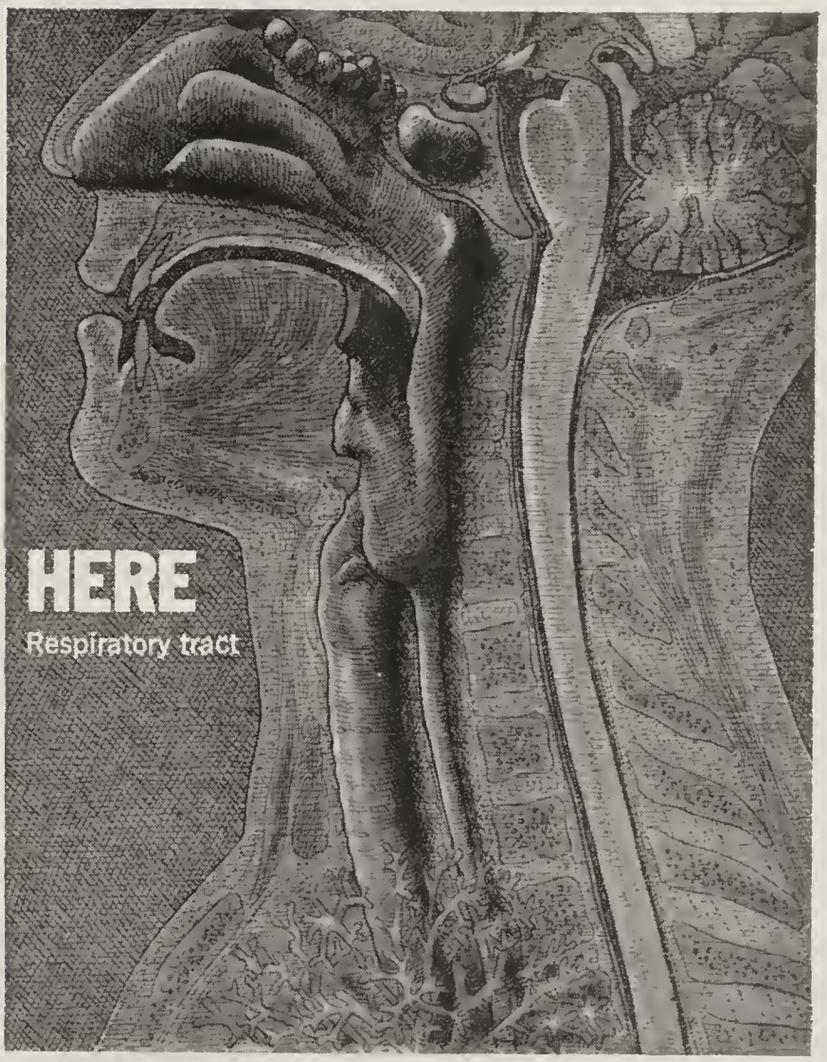
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UMC Newborn Center Holds "Alumni" Party

Hinds County newborn mortality figures per thousand births have steadily decreased to the current 12.8—well below the national average. The University Medical Center's newborn center, credited with bringing the dramatic death rate drop, held its fourth annual Christmas party for newborn center high risk "alumni."

Sixty thriving babies came from as far away as Fort Walton Beach, Fla., where Mr. and Mrs. Bill McBroom and their twin sons live.

Sixteen months ago Mrs. McBroom went into premature labor in Starkville, where they then lived. At birth, her babies weighed about two pounds.

The infants were immediately flown to the Jackson center, where they stayed over two months.

The five-month-old son of Mrs. Bessie Lee Booze of Canton is another newborn center success. Physicians had discovered that the pregnant Mrs. Booze had a cardiac problem. Medication adversely affected her son who is still under treatment for his congenital heart condition.

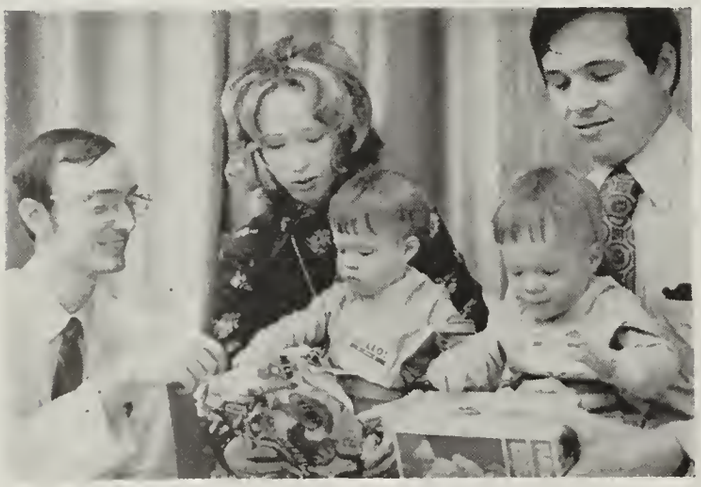
The type of care offered at the newborn center is extending to all of Mississippi. Regional centers have been established in Vicksburg, McComb and Amory to provide the fundamental care necessary for high risk infants.

Five or six other centers may be set up when the initial clinics prove completely successful.

About 400 infants are treated annually in the UMC intensive care center.



Lewis Burke, at center, came into the world as a three-pounder with major respiratory complications. A healthy, happy growing youngster now, he was among UMC newborn center high risk gradnates who returned to the Medical Center for the annual neonatal intensive care unit Christmas party. The Lorman child's father is at left, and Ms. Genevieve Feyen, a UMC nurse-midwife, is at right.



Happiness is two healthy boys for the Bill McBrooms of Fort Walton Beach, Fla. Clint, at left, and Andy, right, were born premature and had to spend nearly three months in the newborn center intensive care unit at the University of Mississippi Medical Center. Doing fine now, they returned to Jackson during the Christmas holidays to see some of their friends at the Medical Center, including Dr. Bill Summers, at left, a UMC pediatric resident. Mr. and Mrs. McBroom are both native Mississippians and were living in Starkville when their twin sons were born.



Six-month-old DeWanda Thomas, at center, of Jackson can't talk yet, but communication's no problem when old friends are involved. One of the UMC neonatal intensive care unit alumni (she weighed just two and a half pounds at birth), she and her mother, at left, were among those who attended the UMC newborn center's annual Christmas party for high risk gradnates. Neonatal nurse Pat Cutrell is at right.

La.-Miss. Internists Plan Biloxi Meeting

The Mississippi-Louisiana Regional Meeting of the American College of Physicians, co-sponsored by the Mississippi-Louisiana Societies of Internal Medicine, will be held at the Broadwater Beach Hotel, Biloxi, Feb. 15-16, 1974.

Mr. Caleb Pirtle, III, travel editor of *Southern Living,* will be the Friday evening after-dinner speaker. Tickets for the banquet are $12.00 each.

Dr. Thomas M. Blake of Jackson and Dr. Chesley Hines, Jr. of New Orleans are program chairmen.

The Feb. 16 morning program consists of selected topics with the afternoon session devoted to "New Thoughts on Old Diseases."

Dr. Lawrence E. Young, F.A.C.P., and Regent, American College of Physicians, will be the Official College Representative. Dr. Young is Professor and Chairman, Department of Medicine, University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

There is no registration fee for members of the three participating organizations, nor for residents, interns and medical students. There will be a $10.00 registration fee for nonmembers. Everyone is invited to purchase tickets to the banquet on Friday and the luncheon on Saturday.

The Mississippi-Louisiana Societies of Internal Medicine will have a luncheon meeting on Saturday, Feb. 16. Dr. George Reich, director of the PSRO for Region IV, HEW, will provide information on implementing professional standards review organizations. Guests are invited and members are urged to attend. Luncheon tickets are $5.00 each.

Please mail hotel reservations directly to the Broadwater Beach Hotel and program registration to Dr. Legrand J. Audioun, VA Hospital, Biloxi, Miss. 39531.

Dr. Guy D. Campbell, F.A.C.P. of Jackson is ACP Governor for Mississippi and Dr. A. Seldon Mann, F.A.C.P. of New Orleans is Governor for Louisiana.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Industrial Health Conference Set

The 1974 American Industrial Health Conference will be held April 28-May 2 at the Americana Hotel in Bal Harbour, Fla. The conference which is comprised of the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses will bring together approximately 2,500 persons including industrial physicians, industrial nurses, safety engineers, industrial hygienists, public health officials, academicians and management representatives.

The scientific program, in which many of the nation's experts in the field of occupational health will participate, will be augmented by both scientific and technical exhibits. Postgraduate seminars and workshops in selected areas of occupational medical practice also will be presented. Registration is open to anyone having an interest in the health of the working population.

For more information write AIHC, 150 North Wacker Drive, Chicago, Ill. 60606.

Dr. John F. Jackson Receives Award

Dr. John F. Jackson, professor of preventive medicine at the University of Mississippi School of Medicine, was recently presented the Harold Cummins Award, in honor of Dr. Cummins, emeritus professor of anatomy at Tulane School of Medicine.

At the annual meeting of the Tulane Medical Alumni Study Club, Dr. Jackson was one of the featured lecturers, discussing progress in human cytogenetics.

A graduate of the University of Mississippi, he holds the M.D. from Tulane University, where he also taught on the faculty.

He has studied at the Institute for Medical Genetics in Uppsala, Sweden, and two years ago took a sabbatical leave from the Medical Center to do further specialty research in Hawaii.

Dr. Jackson's primary research interests also extend to cytogenetics of tumors, hematology and the laboratory aspects of homotransplantation.

Dr. Jackson is a native of Kosciusko.

Emergency Care Unit Opens at Capitol

The MSMA Emergency Medical Care Unit in the Capitol Building at Jackson opened Jan. 8, 1974, for the tenth consecutive year of service during the 1974 Regular Session of the Legislature.

The association's public service project is again staffed by Mavis Barlow, R.N., of Florence. Physician's services are provided by volunteer Doctors of the Day.

The response by the membership to DOD assignment has been wonderful, according to Dr. C. D. Taylor, Jr., of Pass Christian, chairman of the



Senator Perrin Purvis of Tupelo, standing at left, and Senator Ray H. Montgomery of Canton, seated, discuss the current legislative session with Dr. Arthur Derrick of Durant, MSMA president, and Mrs. Mavis Barlow, R.N., EMCU nurse.



Dr. Derrick, MSMA president serving as Doctor of the Day, checks blood pressure of Senator William "Son" Rhodes of Pascagoula in association's Emergency Medical Care Unit at the state Capitol.

Council on Legislation. He added that the month of February is already filled.

Legislative leaders have praised the service which costs the state nothing. Physicians contribute their services, and association funds are used to defray direct expenses. The state furnishes the unit space, a telephone, utilities and janitorial services.

Mrs. Barlow said the unit's practice is brisk. Conditions seen in previous years ranged from the common cold to heart attacks.

CHAMPVA Is New Program for Dependents

CHAMPVA is a new government program for dependents of veterans with a total permanent service-connected disability or dependents of a veteran who dies from a service-connected disability. The benefits and cost sharing are the same as those of retired military personnel and their dependents.

The Mississippi State Medical Association is the Fiscal Administrator for the medical portion and Blue Cross-Blue Shield is the hospital contractor for CHAMPVA in Mississippi.

The claim forms (1863-1, 1863-2) used in filing for CHAMPUS will be used to file for CHAMPVA benefits.

Eligibility will be determined by the Veterans Administration. The VA will issue eligible beneficiaries I.D. cards.

Practice Management Workshop Held



The association and the AMA cosponsored a Practice Management Workshop for new physicians on Dec. 17-18, 1973, at the Holiday Inn Medical Center in Jackson. The attendees are shown at a conference luncheon with Dr. Arthur A. Derrick, Jr., of Durant, MSMA president, as guest speaker.

History of Medicine Society Meets Feb. 28

The History of Medicine Society will hold its next meeting Feb. 28 at the Medical Alumni House on the University Medical Center campus.

Guest speaker is Dr. Godfrey Arnold who will discuss "Historical Highlightings in Otolaryngology."

Dinner will be served at 7:00 p.m. and the talk will begin at 8:00. There will be a $5.00 charge for members for the meal and $7.00 for nonmembers.

For reservations, contact Dr. John Y. Gibson, Department of Radiology, University Medical Center.

Dr. Valenzuela Joins UMC Staff

Dr. Raul E. Valenzuela, former assistant professor of ophthalmology at Baylor College, has assumed the position of associate professor of surgery (ophthalmology) at the University Medical Center.

A graduate of Catholic University in Santiago, Chile, Dr. Valenzuela received his M.D. degree from the University of Chile School of Medicine. He taught at the University of Chile School of Medicine for 17 years before going to Baylor.

New Family Practice Residencies Approved

Eighteen new family practice residencies were approved by the Residency Review Committee for Family Practice at its December meeting, bringing the total of approved FP training programs to 191. The University of Mississippi Medical Center at Jackson was among the 18 new programs which were approved.

Approval of these new residencies provides 243 additional slots for training future family doctors. Eighty-one are first-year openings, a significant figure because the American Academy of Family Physicians' Congress of Delegates recently set a goal of 3,600 first-year slots by 1977—enough to accommodate 25 per cent of each year's total medical graduates.

The review committee, composed of representatives of the AAFP, the American Board of Family Practice and the American Medical Association, meets periodically to examine programs for approval.

SBH Supports Proposed Mental Health Dept.

The Mississippi State Board of Health has issued a position statement regarding proposed enabling legislation which would create a State Department of Mental Health. According to Dr. Alton B. Cobb, State Health Officer and Executive Officer of the Board, the 12-member group strongly favors legislative action to establish a department which would serve as the state mental health, alcohol, drug abuse, and developmental disabilities authorities. Responsibilities for publicly supported mental health services are currently divided among the Board of Trustees of Mental Institutions, the Mississippi Interagency Commission on Mental Illness and Mental Retardation, and the Mississippi State Board of Health. The Board of Health believes that this division of authority results in diminished efficiency and coordination in providing services to the public.

In its statement, the Board expressed a recommendation that a State Board of Mental Health, which would oversee the new department, should include professional persons knowledgeable in health and mental health. It was also the feeling of the Board members that a director of such a department should be a psychiatrist with administrative experience.

To promote a strong alliance and close working relationship between a Mental Health Department and the present Health Department, the Board recommended that the Executive Officer of the State Board of Health be a member of the Board of Mental Health and likewise, that the Executive Officer of the Mental Health Department be a member of the State Board of Health. In addition, it was felt that the public health nursing and other local health department services involved in case-finding and follow-up services to mental patients should be continued through contractual arrangements with the Department of Mental Health.

The Board also requested and strongly urged that employees of the three agencies presently having mental health responsibilities be incorporated into the new department and that efforts be made to assure against any interruption in the services and programs now administered by the three state agencies with mental health responsibilities.

In regard to the legislation itself, the Board favors delaying any change in commitment procedures until the new department could plan and propose recommendations for such changes.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms) anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections, an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q i d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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Mississippi PSRO Area Designated

Mississippi has been designated a statewide Professional Standards Review Organization (PSRO) area in regulations issued by the Secretary of HEW in accordance with Public Law 92-603. The tentative regulations, issued Dec. 10, 1973, and becoming effective Feb. 5, 1974, designate Mississippi and 24 other states as statewide PSRO areas.

Public Law 92-603 was passed by Congress in 1972 and under its provisions dealing with PSROs the Secretary of HEW was to designate PSRO area(s) for each state prior to Jan. 1, 1974, preparatory to accepting applications to serve as Professional Standards Review Organizations from professional organizations representing practicing physicians between Jan. 1, 1974, and Dec. 31, 1975. After the latter date the Secretary may accept applications from any "qualified organization" to include health insurance carriers, state health departments or similar type organizations.

A controversy over PSRO area designations has raged for the past several months particularly in large states where well organized county medical societies, the state medical society, and several foundations for medical care have each fought for PSRO leadership.

The PSRO area designation hearing for Mississippi was held in Jackson on Aug. 7, 1973, and was attended by representatives of the Mississippi Hospital Association, Mississippi Medicaid Commission, the Blue Cross and Blue Shield Plan of Mississippi, Inc., Travelers Medicare, the Governor's Office of Federal/State Programs, the West Mississippi and Northeast Mississippi medical societies, the Mississippi State Board of Health, the Mississippi State Medical Association, and the Mississippi Foundation for Medical Care, Inc. It was the formal recommendation of the association, based upon alternatives offered, that the state be designated a statewide PSRO area. The Mississippi Hospital Association and the Mississippi State Board of Health formally acknowledged approval of the association's proposal and representatives of the other organizations present offered no dissent to the proposal.

The association-sponsored Mississippi Foundation for Medical Care was instructed by the House of Delegates at the 1973 annual session to proceed to implement PSRO in Mississippi in accordance with Public Law 92-603. The foundation has formally applied to serve as the PSRO for Mississippi. The foundation was awarded an initial PSRO planning grant by the Mississippi Regional Medical Program in November and a committee composed of foundation members has been working on a PSRO plan for Mississippi.

Records Librarian Assist EMCRO

With the assistance of Doris Harris, RRA, president of the Mississippi Medical Records Association, representatives from state regions of MMRA have been appointed to serve in an advisory capacity to the EMCRO staff record administrator, Mrs. Phyllis Iccomb, RRA.

The first meeting of the group was held Dec. 14, 1973, for consideration and discussion of the forthcoming changes in the EMCRO's data gathering operations. These changes will incorporate statistical data and indices to be provided by EMCRO to participating hospitals, as well as a glossary and drug cross reference to be included in the procedure manual to accompany the new edition of the criteria to be distributed at a spring workshop. The advisory panel will assist in the development and presentation of this workshop.

Members of the advisory panel are: Mesdames Jackie Whitmore, RRA, director, University School of Medical Records, Jackson; Terry Ragland, MRA, Tupelo; Margaret Given, ART, Vicksburg; Mary Price, RRA, Pascagoula; Frances Ezell, ART, Greenwood.



The advisory panel to EMCRO medical records staff consists of from left: Mrs. Phyllis Iccomb, RRA, EMCRO staff; Mary Price, RRA, Pascagoula; Frances Ezell, ART, Greenwood; Jackie Whitmore, RRA, Jackson; Terry Ragland, MRA, Tupelo; and Margaret Given, ART, Vicksburg.

Sen. Kennedy Begins Drug Hearings

Sen. Edward Kennedy's Health Subcommittee hearings on the drug industry lived up to their explosive expectations with HEW Secretary Casper Weinberger throwing the first bomb by announcing that the administration would propose a cost-saving drug plan for Medicare and Medicaid patients under which reimbursement would be limited to "the lowest cost at which the drug is generally available."

Estimating the savings at from $25 to $60 million a year, the HEW proposal was a blow to the pharmaceutical industry which viewed it as a step toward generic prescribing and a setback to the brand name concept. Congress would have to approve the proposal, however.

Under questioning from subcommittee members, Weinberger was vague about how the program would work, but emphasized that physicians would remain free to prescribe as they choose. Sen. Kennedy praised the proposal. Sen. Gaylord Nelson (D. Wis.) said the HEW recommendation "must be only the first step in a massive intrusion by the federal government into the prescribing habits of physicians."

The first day's session featured charges that drug companies are monopolistic, keep prices jacked high, and spend huge amounts on advertising. Physicians were described as inept and too generous prescribers of drugs influenced inordinately by advertising and drug detail men. It was implied that 100 deaths a day due to adverse drug reactions were the fault of the drug industry and the prescribing physicians.

Sen. Nelson, a new subcommittee member, urged that prescription drug advertising be banned and trade names eliminated. Consumer advocate Ralph Nader agreed and recommended patent restriction.

In an opening statement, Kennedy said the hearings are designed to "search for legislative solutions to the problems surrounding the way drugs are developed, marketed and used in this country." He said "Too many physicians are prescribing too many drugs on the basis of too little information . . . such irrational prescribing is a product of physician ignorance, not malice. . . ."

Kennedy's subcommittee had never before asserted broad jurisdiction in the drug field. The hearings were viewed as a stake-out to this aspect of health and government, and also as a bow to Nelson who has been investigating the drug industry for years and is its strongest critic on Capitol Hill. His previous forum was a Senate small business subcommittee.

Dr. James H. Sammons, chairman of the Board of the American Medical Association, told the subcommittee that in the heat of controversy it should be emphasized that "Today there are a large number of drug preparations available through a complex delivery system replete with checks and balances provided by industry, the Food and Drug Administration, physicians, pharmacists, and in some instances allied health personnel."

Dr. Sammons continued, "It is not surprising that this complex and important system carries with it complex problems that different groups within the system perceive differently . . . simple solutions for the management of our problems are not realistic."

The AMA official said the reduction in funding for research investigators could have an adverse effect on development of improved drugs. The complexity of FDA procedures "is becoming self-defeating and some new approaches are required if we are to be able to provide new and useful therapeutic agents to alleviate existing maladies."

Whatever is done, Dr. Sammons said, "the physician must be able to prescribe the drug in dosage and strength deemed appropriate for his patient. . . ."

"Where appropriate, we believe the physician should prescribe the least expensive product," Dr. Sammons testified. "But the generic name on the bottle is not a guarantee of equivalence, nor for that matter does a generic prescription even guarantee to the patient that he will receive the least expensive product."

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, testified that, "What the secretary is proposing represents an extraordinarily radical approach to health care, one which may give the appearance of providing first class medical care at less cost, but which will either require Medicare and Medicaid beneficiaries to accept inferior products or force them to pay the cost of first class medicines from their own household budgets."

Stetler said the proposal might have some merit if therapeutic equivalence of drugs could be assured, "but the published evidence is almost entirely on the other side. Reports of the clinical inequivalence of drugs sold under the same generic name are increasing as are quality control failures."

On another tact, Stetler said new drug discoveries have been a major contributor to improving health

care, and that drug prices have held stable in a period of soaring inflation.

But, he warned, America is falling behind foreign competitors in the rate of pharmaceutical innovation, adding that the industry's pattern of discovery of new drugs and the stable prices of medicines are threatened by proposals to reduce incentives for drug producers to continue their massive research programs.

"Price setting, dilution of patent rights, or a government takeover of research and development or promotional activities," suggested by some, would be self-defeating and lead to higher prices and lower productivity, Stetler said.

Although the industry's dollar investment in research is continuing to climb, Stetler testified that fewer American pharmaceutical firms are sponsoring such activities due, in part, to the tangle of government delays and regulations.

In his testimony, Sen. Nelson said the AMA "has cooperated in creating confusion" and has been "disastrous in this field because the custodians of health care in this country are the guide to us on what good medical practice is." The AMA "has done more damage to the good practice of drug prescribing than if it did not exist at all," Nelson said. The AMA's drug manual was "degraded" due to pressure from drug companies . . . "For money! It is as simple as that," he asserted.

Nader accused the industry of "price gouging and causing serious harm to tens of thousands of people that is unparallelled in history."

The hearings will resume later this winter and continue through to summer.

Symphony Membership Is Now Available

The Jackson Symphony Orchestra will present musical artists of international renown in its seven concert series for the 1974-75 season with the theme "The Wide, Wide World of Music."

Tickets and association memberships are available now through Feb. 21 from any Fund Drive worker or the symphony office, P.O. Box 4584, Jackson.

Opening the series on Sept. 30 and Oct. 1 is the well known bass, Justino Diaz. He'll be followed by the dynamic entertainer, Ella Fitzgerald who will display her vocal talents in a gala concert with the symphony on Oct. 25.

Guest conductor Allun Frances will appear along with pianist Leonard Pennario on Nov. 4 and 5.

The holiday season concert will present the First Chamber Dance Company of New York in twin performances Dec. 9 and 10.

Bette Davis, acclaimed actress of stage and screen, will open the 1975 year with a narration accompanied by the orchestra Jan. 27 and 28.

The Delta State College Choir, under the direction of Robert VanBuskirk, will appear Feb. 24 and 25. Guest harpist Susanna Mildonian will perform Mar. 24 and 25 in the final concert of the season.

As a bonus to those who purchase tickets for the 1974-75 season as new members, the symphony is presenting tickets to the Duke Ellington Gala Concert scheduled for the Mississippi Coliseum in Jackson Mar. 29, 1974.

Association memberships include: Patron ($45), Donor ($100), Sponsor ($250), Benefactor ($500), and Grand Benefactors ($1000). Regular season tickets are $16 for adults and $6 for students.

Fund Drive Chairman, Mrs. Harlon H. Varnado, and her Cochairmen, Mrs. George Bell, Jr., and Mrs. Manning Hudson, urge everyone to take advantage of the opportunity to support the state's largest cultural force.



Acclaimed harpist Susanna Mildonian is shown with her instrument. Miss Mildonian is one of seven guest stars scheduled to appear with the Jackson Symphony Orchestra during its 1974-75 concert series.

ORGANIZATION / Continued

Dr. Derrick Speaks to South Miss. Society



Dr. Arthur Derrick, Jr., of Durant, MSMA president, at left, addressed the December meeting of the South Mississippi Medical Society at the Hattiesburg Country Club. Shown with him are Mrs. John E. Green, president of the Hattiesburg Medical Auxiliary, and Dr. Emmett Herring, president of the Hattiesburg Clinical Society.

Clinical Cardiology Course Scheduled

The most difficult problems commonly encountered in the modern practice of cardiology will be the topic of the postgraduate course entitled, "Practical Problems in Clinical Cardiology," Playboy Plaza Hotel, Miami Beach, on Feb. 25-Mar. 1, 1974. Sponsors for this course are the American College of Chest Physicians and the Mount Sinai Medical Center.

Recognized experts will discuss the problems of myocardial infarction, pulmonary edema, bacterial endocarditis and respiratory insufficiency. Main emphasis will be placed on patient management encountered in every day practice. A free exchange of information between faculty and participants will be encouraged through small group discussions.

At the conclusion of this course, the participant should be able to recognize and treat the difficult cardiac arrhythmias encountered in his daily practice, develop a rational approach toward the evaluation of the patient with chest pain through exercise

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testing and coronary angiography, properly selecting those patients most likely to benefit from coronary artery surgery and develop guidelines for identifying patients who would benefit from pacemakers and managing patients with permanent pacemakers.

Registration fees for this course are: ACCP members, $125; non-members, $150; and residents, $75. For further information write: Bradford W. Claxton, M.Ed., Director of Continuing Education, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

Shock Course Set for Honolulu

Physicians with a special interest in the treatment of respiratory distress are encouraged to attend the postgraduate course, "Respiratory Care in Shock Syndromes," Mar. 4-6, 1974, at the Hilton Hawaiian Village Hotel, Honolulu, Hawaii. This course is sponsored by the American College of Chest Physicians and the University of Hawaii School of Medicine.

This three-day program will summarize the latest developments in the area of respiratory care following shock and other injuries. A special feature of the course will be a session on underwater pulmonary barotrauma and the effects of injuries caused by marine life. The program will feature intensive early-morning sessions, with free time during the afternoon for individual study and assimilation of the material presented. Panel discussions and question-and-answer periods will facilitate participant interaction with the faculty. Nurses and senior respiratory therapists are invited to attend.

Registration fees for this postgraduate course are: ACCP members, $125; non-members, $150; and residents, nurses and therapists, $75. For further information contact: Bradford W. Claxton, M.Ed., Director of Continuing Education, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

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State PSRO Subcommittee Holds Jan. Meeting



Members and staff consultants of the Mississippi Foundation for Medical Care Subcommittee on PSRO Planning are shown at the committee's Jan. 8 meeting in Jackson. Members of the subcommittee are: Drs. J. T. Davis of Corinth, president of the foundation; Tom H. Mitchell of Vicksburg, chairman; Richard C. Miller of Jackson; William H. Preston, Jr., of Booneville; J. P. Culpepper, III, of Hattiesburg; James W. Rayner of Oxford; C. D. Taylor, Jr., of Pass Christian; and Kenneth P. Pittman of Jackson.

Forensic Scientists Meet in Dallas

The 26th Annual Meeting of the American Academy of Forensic Sciences will be held at the Statler-Hilton, Dallas, Feb. 12-15, 1974.

More than 250 speakers and panelists from throughout the nation and from Canada, Denmark and Germany will take part in some 70 scientific and medicolegal programs and events to be conducted by the academy and its nine sections.

The National Association of Medical Examiners, the Forensic Sciences Committee of the American Society for Testing and Materials and the National Safety Council's Alcohol and Drug Committee have scheduled their annual meetings on Feb. 12, preceding the AAFS program.

Dr. Morton F. Mason, director of Dallas County Criminal Investigation Laboratory and the president of the academy will open the general session on Feb. 13, setting the theme for the 1974 gathering—the application of computers and scientific instrumentation to the forensic sciences.

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

Jan. 28-Feb. 10 — *The Case of the Tingling Hand,* with Frank M. Howard, M.D., Associate Professor of Neurology, Mayo Medical School, Rochester, Minn.

Mononucleosis in the Clinic and the Lab, with James C. Niederman, Associate Clinical Professor of Epidemiology and Medicine, Yale University School of Medicine, New Haven, Conn.

Management Tips for Soft Tissue Injuries in Children, with Thomas S. Morse, M.D., Associate Professor of Surgery, Ohio State University College of Medicine.

Feb.11-24 — *Paul D. White: Cardiology in My Time.* The late Dr. Paul D. White describes the development of cardiology as a specialty. This special program was first introduced during the American College of Cardiology annual meeting in 1968 and is offered again on the anniversary of that meeting.

The Distressed Newborn: The First 30 Minutes, with Peter A. M. Auld, Director, Neonatal Intensive Care Unit, and Professor of Pediatrics, New York Hospital—Cornell Medical Center, New York.

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change)

AMA Will Cosponsor Australian Conference

On March 22 through April 7, 1974, the AMA will cosponsor with the Australian Medical Association a trip to Australia for the 2nd International Health Conference.

Physicians who desire additional information may write or *call collect:* Mr. Al J. Facca, Assistant Director, Management Services Division, 535 North Dearborn Street, Chicago, Ill. 60610, (312) 751-6117.

CLASSIFIED

NEEDED: One physician to work in an active University Student Health Center beginning July 1, 1974. Please contact J. C. Longest, M.D., Director, Mississippi State University, P.O. Box 5448, Miss. State, MS 39762. Phone: 601-1-325-2431.

PHYSICIAN ASSISTANT: B.S. biology, pre-med and German, 5-yr. experience in medical technology, 3-yr. experience research biochemistry. Desires position with G.P. in rural practice. Available May 1, 1974. Tom Summers, Box 18, 230 Hwy. 49 South, Jackson 39208.

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IN CONCLUSION

Effective Jan. 1, all insurance companies doing business in Oregon are required to use the AMA's uniform claim form for health insurance. The form, developed by an AMA-sponsored work group, was recommended to the state insurance commissioner by a study committee he appointed following the Oregon Legislature's action requiring a uniform claim form. AMA's Department of Health Insurance reports several medical societies are investigating the possibility of similar action.

Suicides defy any fixed seasonal or climactic patterns, reports the January issue of Archives of General Psychiatry. Researchers at Duke University Medical Center and Durham V.A. Hospital analyzed reports of 3,672 deaths by suicide in North Carolina from 1965-1971. They found no major upsurges for special holidays, weekdays versus weekends, months or seasons. Highest percentage of suicides was noted on Monday. Early recognition of depression is most effective prevention

---

Behavioral disturbances in children are probably the most important and dramatic of the adverse reactions attributable to food additives, Ben Feingold, M.D., Kaiser Foundation Hospital, told Section on Allergy at AMA 1973 convention. He stated that hyperkinetic patterns of children are successfully treated with salicylate-free diets that also eliminate 80% of food additives. Dr. Feingold cited a Calif. study estimating that incidence of hyperkinesia has risen to 20-40%.

The Wall Street Journal reports that unions have stepped up their monitoring of unsafe working conditions. Members of the Oil, Chemical, and Atomic Workers Union submit their hair and urine samples to a union-hired laboratory. Connecticut fire fighters take periodic heart tests to measure job stress. Teamsters Union drivers monitor truck-cab air for carbon monixide. A United Auto Worker safety expert says the trend is toward creation of environmental shop stewards.

National Formulary has announced a proposed official standard for tightness of drug containers. Proposal includes a test procedure of relatively simple design for containers as well as suggested limits for "tight" and "well-closed" containers, as defined by official compendia. Proposed requirements are applicable to multiple-unit containers. Comments on the proposal should be sent within 60 days to the National Formulary, 2215 Constitution Ave., N.W., Washington, D.C.

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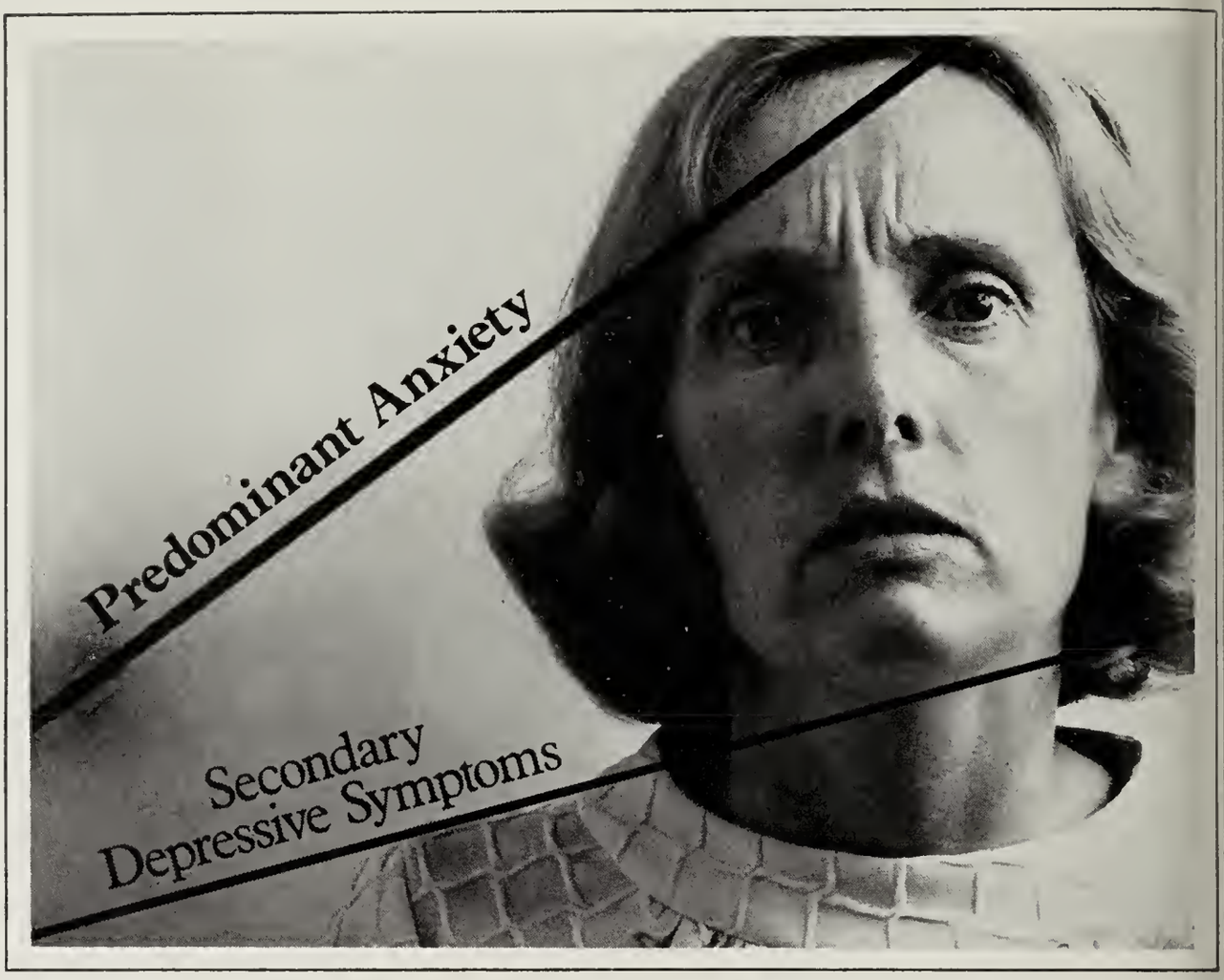
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This Month . . . Childhood Urinary Infections, Intrathoracic Lymphnodal Hamartoma, Colon Cancer, Osteomalacia

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Volume XV
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What's on your patient's face...

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Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



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*Data on file, Hoffmann-La Roche Inc., Nutley, N.J



NEWSLETTER

March 1974

Dear Doctor:

Persons who have had malaria may now be eligible to donate blood plasma, American Red Cross and American Association of Blood Banks have announced. Restrictions have been amended to permit persons who have had malaria to be accepted if they've been free of symptoms and have not taken antimalarial drugs for 3 years. Change is based on fact that malaria is transmitted by cellular components of blood.

The two groups have also jointly announced that the permissible age for donating blood has been lowered to 17 (it was previously 18). A 17-year-old donor still will require consent of his parents or guardian, unless he is married, self-supporting or in the military.

The MSMA Council on Scientific Assembly is currently conducting negotiations with the Sheraton-Biloxi Hotel in regard to the 106th Annual Session. In order to identify areas which need improvement, the council would like to hear from members with specific complaints. Write to the council at P.O. Box 5207, Jackson 39216.

The nation's costs for health care rose to $94.1 billion in fiscal year 1973 -- an increase of 11 per cent over the $84.7 billion spent in fiscal year 1972 -- according to a preliminary HEW report. It was lowest increase in several years, said HEW's Social Security Administration. Final figures could increase the total slightly.

St. Paul Fire and Marine Insurance Company has introduced a new bimonthly publication, Malpractice Digest, designed "to help you and your associates determine what you can do in practice and patient communication to reduce the potential for malpractice." Digest will go to all St. Paul medical liability insurance policyholders.

Infectious syphilis rates have shown a leveling off, the Center for Disease Control reports. State health departments reported 5.8 per cent fewer cases in Sept. 1973 than in same month in 1972. For April-Sept. period, reported cases totaled 13,580, up only 0.1 per cent over the number reported for that period in 1972.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Safeguards Urged for Preadolescent Gridders

Doctors who long sought to discourage rough contact sports for small children have now faced up to the fact that, dangerous or not, small boys are going to play football.

Thus it behooves the medical profession to set up guidelines and safeguards that will permit the youngsters to play with a minimum of injury risk.

Actually, reports Dr. Melvin L. Thornton of the University of Texas Medical School at San Antonio, the injury rate among preadolescents is lower than once believed, because the force of contact is not so great as in the bigger, older and stronger lads. The 9- or 10-year-old does not have the maturity, coordination or the intense desire to hit with abandon, says Dr. Thornton in a recent *JAMA* article.

Guidelines recommended for contact sports for small children include proper physical conditioning, good coaching, modification of rules, careful grouping by size, age and weight, good equipment, well-maintained playing fields and facilities, careful management by responsible adults, adequate medical care and attention to educational and recreational considerations.

The Texas doctor recommends a good conditioning program for all children from kindergarten at least through high school. This will not only be good for sports, it also will help reduce heart disease problems. Running is first-rate for improving oxygen consumption and preparing the child for strenuous sports.

There is no reason that preadolescent children should play by the same rules as high school or college students, he says. In one state junior high school rules were changed to eliminate the kickoff and to play with a slightly deflated football.

The practice of passing old, damaged, ill-fitting athletic equipment from the high school down to the elementary school is condemned.

"The cranium and its contents of the preadolescent are just as important as those of the older athlete."

A thorough medical examination is strongly urged for all children participating in sports. The physician is urged to evaluate each child in terms of physical capabilities for the sport in question.

"Intercity playoffs, bowl games and all-star games (for preadolescents) are to be deplored. Even excessive publicity, pep squads and inappropriate spectator behavior are to be avoided."

Dr. Thornton is a member of the American Medical Association's Committee on Medical Aspects of Sports.

Rondomycin®
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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
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DATELINE

Assessing Dead Heart Tissue

Chicago, Ill. - A way of assessing the extent of dead heart tissue resulting from a heart attack has been described by University of Chicago investigators. Dr. Paul V. Harper, professor of surgery and radiology, said the method involves injecting radioactive ammonia into a vein. The ammonia seeks out the undamaged part of the heart, and radiation is detected outside the body with a nuclear camera.

Loan Repayment for Service

Bethesda, Md. - Loan repayment to health professionals in exchange for service in areas of need is now available through a new HEW program. Professionals who borrowed money for their education are eligible. For two years of service in a shortage area, HEW will pay loan installments up to 60 per cent of the principal (plus interest as it falls due); for three years of service, HEW repays 85 per cent.

The AMA's 1974 Budget

Chicago, Ill. - AMA's proposed budget for 1974 is $37.3 million, 10 per cent more than 1973 expenditures. Largest portion of the 1974 budget -- about 77 per cent -- aimed toward 3 major goals: better delivery of medical care service, higher quality medical care services, and persuading Americans to be more mindful of their own health. Income is from dues, advertising and subscription revenues.

New Family Practice Magazine

Kansas City, Mo. - The American Academy of Family Physicians has launched a new publication -- the AAFP Reporter -- a monthly news and feature bulletin designed to inform AAFP members of major happenings in family medicine. Executive Director Roger Tusken said, "This news magazine will give academy members more -- and more current -- news about important events affecting the specialty..."

Legislators Address People

Jackson, Miss. - The Mississippi Legislature now has its own hour-long weekly opportunity to address the people of Mississippi on "Quorum," which is broadcast live over the Mississippi Educational Television Network. This new addition to ETV's public affairs programming is aired live each Thursday at 6:30 p.m. and will continue the entire session. Toll-free number to call in questions is 1-800-222-8003.

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Endocrinology Meet Set for London

Symposia Medica Foundation presents an International Conference in Endocrinology, with emphasis on Gynecological Aspects, to be held in London, England, May 31-June 8, 1974.

For further information, contact: Ms. Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York, N.Y. 10010.

Newborn Testing Urged for Sickle Trait

Routine screening of blood samples from umbilical cords of infants immediately after birth to detect sickle cell diseases is recommended by a medical research team from Yale University School of Medicine in a report in the Jan. 28 issue of the *Journal of the American Medical Association.*

Sickle cell anemia occurs with an estimated frequency of 1 in 600 births among black Americans.

In a research study conducted at Yale-New Haven Hospital, eight of 756 black and Puerto Rican newborns screened during one year had major sickling blood problems, the doctors report.

"Identification of affected infants should permit anticipation and, hopefully, prevention of major catastrophic complications that contribute to the high mortality for sickle cell diseases in the first years of life."

The tests cost only $3.50 each, taking less than two hours to complete, requiring simple and inexpensive equipment and can be performed by individuals with little technical training.

"Early recognition of sickle cell anemia is a valid medical goal. There is as yet no specific therapy for sickle cell anemia, but many of the complications, including life-threatening episodes of overwhelming infection crises, can be minimized by early medical intervention.

"Diagnosis at birth permits utilization of the first few months of life for parental education and counseling and for ensuring that direct access to prompt and competent medical and social resources is provided. Genetic counseling of the family concerning future pregnancies can also be given."

The research study was conducted by Howard A. Pearson, M.D., Richard T. O'Brien, M.D., Sue McIntosh, M.D., Gregg T. Aspnes, M.D., and Mei-Mei Yang, M.S.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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College of Surgeons Plans Spring Meeting

The American College of Surgeons will hold its second annual four-day Spring Meeting in Houston Mar. 25-28, 1974, at the Albert Thomas Convention Center and the Hyatt Regency Hotel.

The meeting will provide eight postgraduate courses, some of which will feature plenary sessions, followed by workshops to facilitate participation and discussion. A surgeon may choose one of four courses during the first two days of the meeting, and select another from four other offerings in the second two days.

The nine-hour postgraduate courses will be supplemented by two days of symposia, panels, lectures and motion pictures.

Industrial exhibits will be open in the Albert Thomas Convention Center Mar. 25-27.

Fees for the postgraduate courses, approved by the American Medical Association for credit as continuing education courses, are $40.00 for all registrants, manual included. Registration for this meeting is a prerequisite for registering in the postgraduate courses.

Registration for the meeting will be free of charge to Fellows of the college whose dues are paid through 1973, members of the ACS Credentials Group, and surgical residents. Non-Fellows, applicants for Fellowship and Fellows whose dues have not been paid, pay $50.00. Non-Fellows in the Federal Services (fulltime) pay $30.00.

Registered nurses and interns who present proper credentials may register free of charge for the general sessions and exhibits, but are not eligible for the postgraduate courses.

Housing and registration forms are available from the ACS, 55 East Erie Street, Chicago, Ill. 60611.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
March 1974, Vol. XV, No. 3

ORIGINAL PAPERS

Urinary Tract Infections in Childhood

JAMES E. KEETON, M.D.
Jackson, Mississippi

The urinary tract is second in frequency to the respiratory tract as a site of bacterial infection in children. The author discusses the difficulties in diagnosis and points out the possible serious consequences of failure to diagnose these infections. He emphasizes the importance of urine culture to confirm the diagnosis and voiding cystourethrogram and intravenous pyelogram to exclude underlying abnormalities. If abnormalities are present, surgical correction may be advisable.

THE URINARY TRACT is second in frequency to the respiratory tract as a site of bacterial infection in children. Because of difficulty in interpretation of signs and symptoms and the problems involved in collection of valid specimens, the disease is often overlooked. The importance of the diagnosis and adequate treatment should be viewed in two perspectives. The infection itself is important because of the morbidity of the acute illness and its potential chronic effect on the kidneys. Infection must also be viewed as a frequent sign of underlying congenital abnormalities which may threaten the kidneys and outflow tracts even in the absence of infection.

Urinary tract infection in children occurs almost exclusively in girls except in the newborn. Kunin's survey of school children in Charlottesville, Virginia, showed an incidence of asymptomatic bacteria of about 1 per cent in girls and 0.026 per cent in boys.[1, 2] The incidence of urinary infection in girls is greater in the first three years of life and decreases with age until after puberty when sexual activity begins.[3]

The symptoms of urinary tract infection in children are numerous and are largely related to the age of the child.[4] In the neonate and up to the age of two, urinary tract infections must be suspected when there is failure to thrive, fever of unknown origin, evidence of septicemia, diarrhea, vomiting, dribbling, and cloudy or odorous urine since the child at this age is unable to interpret subjective symptoms.

Between the ages of two and five, the more common symptoms are fever, abdominal pain, urinary frequency, and enuresis. Also, dysuria and hematuria are occasionally seen. After the age of five, the more classical symptoms of cystitis or pyclonephritis are found. They are dysuria, frequency, flank pain, fever and chills.

Physical signs are relatively few in the child with a urinary tract infection. However, one should observe carefully for palpable kidney or bladder, both of which are often indicative of some type of congenital abnormality. Hypertension and congenital malformation of other systems are sometimes found.

After one suspects that a child may have a urinary tract infection, the diagnosis is confirmed by the examination of a fresh, clean urine specimen. This specimen should be examined microscopically and cultured prior to any antibiotic treatment. The method of obtaining a urine specimen from a child

From the Departments of Surgery (Urology) and Pediatrics, University of Mississippi Medical Center, Jackson, Miss.

is influenced by the age of the child. In the younger child, the easiest method is to clean the external genitalia with an antiseptic solution, rinse with distilled water and then apply a sterile plastic adhesive bag to the perineum. After the child micturates, the specimen is then examined and cultured immediately. Occasionally, one may need to use a urethral catheter or suprapubic aspiration, but under most circumstances the simple method of collection with the bag is all that is needed. The older child can void on command and a clean catch midstream urine can be obtained. Suprapubic aspiration of urine is most helpful in the neonatal period.

It is generally accepted that a growth of 100,000 bacteria per millimeter on a fresh, clean specimen indicates urinary infection. However, a child may have infection with a colony count between 50,000 and 100,000 bacteria per millimeter. Colony count is particularly important in interpreting bacterial growth in a specimen collected by the adhesive bag technique because of contamination from the skin. The routine urinalysis is helpful if pyuria is present, but the child may have a urinary tract infection without pyuria; so it is most important that a urine culture be obtained. Simple screening aids for bacteriuria are available. An example of such is the Testuria* culture tray to which urine is applied with a special paper strip. If negative, no further study is needed and the urine is considered sterile. If positive, a complete identification of the bacteria with antibiotic sensitivity can be done from the tray.

EVALUATION

After suspecting the diagnosis of urinary tract infection in children, confirmation is obtained by the microscopic examination and culture of a properly collected urine specimen. Treatment of the acute episode may proceed on this basis, but further evaluation is necessary to exclude underlying abnormalities which predispose to infection.[5] We believe that this evaluation should follow the first infection instead of waiting for recurrences. Any child with a urinary infection should have a voiding cystourethrogram followed by an intravenous pyelogram. The studies should be done after the infection has been brought under control with appropriate antibiotic treatment, usually about two weeks after start of treatment when the urine culture is sterile. This is done because infection itself can cause radiographic abnormalities such as vesico-ureteral reflux. If the combination of voiding cystourethrogram and intravenous pyelogram is normal, further studies are seldom indicated (see Figures 1 and 2). Medical management should be instituted then. However, when these studies are done on every child with urinary tract infection, there is about a 30 per cent incidence of vesico-ureteral reflux[6] (see Figure 3). Scarring of the kidney gross enough to produce radiological evidence occurs in about 13 per cent of children (see Figure 4). When there is evidence of chronic pyelonephritis on the intravenous pyelogram, vesico-ureteral reflux will be found in most cases. The high incidence of chronic pyelonephritis and reflux shows the importance of the voiding cystogram. Pyelonephritis and vesico-ureteral reflux are the most common abnormalities found. Other abnormalities associated with urinary tract infection such as urethral valves in boys, urethral stenosis, ureteral duplication and ectopia, congenital ureteropelvic obstruction and, occasionally, calculi. If there is an abnormality on the intravenous pyelogram or voiding cystogram, additional studies may be needed, the most common of which is cystoscopy. At the time of cystoscopy, the caliber of the urethra and the size, shape, and position of the ureteral orifice can be evaluated. Occasionally, a retrograde pyelogram and more sophisticated studies such as renal scans, renograms, and arteriograms are needed.

SYMPTOMS OF CHILDREN WITH URINARY TRACT INFECTIONS
Failure to thrive, feeding problems
Screaming attacks, irritobility
Offensive or cloudy urine
Diarrhea
Vomiting
Fever
Convulsions
Hematuria
Frequency or dysuria
Enuresis
Abdominol pain
Loin pain

*Testuria Diagnostic Aid, Ayerst Laboratories Incorporated.



Figure 1. Normal voiding cystogram.



Figure 2. Normal intravenous pyelogram.

The main objectives in the management of a child with a urinary tract infection are to eradicate the infection, to prevent recurrence and to protect the kidney from damage. Most children with urinary tract infections can be managed with careful use of antibiotics and close follow-up. However, some will need surgery along with medical treatment.

As stated previously, if there is no abnormality on the intravenous pyelogram or voiding cystogram, then medical management is indicated. Medical management consists of treatment with the appropriate antibiotic for 10 to 14 days. A urine culture is done after the child is off medication to confirm that the infection is eradicated. Since E. coli is the most common organism, the usual first choice of antibacterial agent is either one of the sulphonamides or nitrofurantoin. Initiation of treatment should not be delayed for the culture and sensitivity, but if this report shows an organism not sensitive to the above drugs, then the appropriate adjustment in antibiotic therapy should be made. Further follow-up consists of a urine culture and sensitivity every three months for at least one year to check for asymptomatic bacteriuria. If the infections recur at a rapid rate and become difficult to control with short term therapy, long term treatment may be needed. This usually consists of three to six months treatment with an antibacterial agent such as sulphonamide or nitrofurantoin. A few patients must be kept on antibacterial agents for years and may require repeat urological evaluation even if the studies were previously normal. Good fluid intake and frequent voiding are also desirable in the management program, but the young child may be unable to cooperate. Ancillary measures such as perineal hygiene, avoiding bubble baths, etc. may be helpful.

The most common abnormality found in children with urinary tract infections is vesico-ureteral reflux. This can occur in one or both ureters. Normally, urine should pass from the ureter to the bladder via the uretero-vesical junction without obstruction, but should not, on filling or voiding, go back up the

ureter if this junction functions properly. Reflux of urine up the ureter is abnormal. Reflux can be caused by infection and, if so, will cease when appropriate treatment has been given. However, the reflux is sometimes secondary to a congenital abnormality of the uretero-vesical junction with deficiency of the normal valve-like mechanism. If this is the cause of reflux, a decision between surgical or medical management of the reflux is required. The decision to perform antireflux surgery (ureteral reimplantation) is based on several factors: (1) Gross scarring of the kidneys on intravenous pyelogram; (2) Abnormal ureteral orifices seen at cystoscopy which will probably not improve with control of the infection or with growth of the child; (3) The degree of reflux and extent of dilatation of the ureters seen on the voiding cystogram; (4) Difficulty with the control of the urinary tract infection.

If one or all of these factors are present, antireflux surgery is probably needed. The surgery may control the recurrent urinary tract infections, but it is primarily done to protect the kidneys from retrograde infection from the bladder. Even after antireflux surgery, some 30 per cent of children continue to have difficulty with urinary tract infections, but the infection is usually limited to the bladder and is more easily controlled with antibacterial agents. Antireflux surgery is not without hazard but in experienced hands it is successful in curing the reflux in about 95 per cent of the cases. The risk of obstruction as a complication can be expected in one to two per cent of reimplanted ureters.

Urethral stenosis in girls is sometimes a cause of urinary tract infection, but the frequency of the abnormality has been exaggerated in recent literature. The zeal of urologists in searching for anatomic causes of urinary infection has probably led to many unnecessary operations of the female urethral



Figure 3. Voiding cystogram showing left vesicoureteral reflux.



Figure 4. Intravenous pyelogram showing left chronic pyelonephritis.

meatus, but, in selected cases, dilatation or internal urethrotomy may be indicated to relieve obstruction and aid in the management of recurrent infections.

Any type of abnormality which causes obstruction to urinary outflow will probably have to be managed surgically. Examples of these conditions have been cited.

SUMMARY

Urinary tract infections in children can be difficult to suspect. Once suspected, however, the diagnosis is easy to confirm with urine culture. Failure of diagnosis entails the danger of chronic pyelonephritis and, in some cases, renal failure. It behooves all physicians who care for children to be cognizant of the unusual symptomatology and the paucity of signs of urinary tract infection. After the diagnosis is confirmed, a few simple tests, i.e., voiding cystourethrogram and intravenous pyelogram, may be used to exclude underlying abnormalities. If no abnormalities are present, then the patient can, in most cases, be managed by the family physician or pediatrician with antimicrobials and with careful monitoring for recurrence. If abnormalities are present, further urological evaluation is needed by a urologist. Surgical correction of anatomic defects may be advisable. ★★★

2500 North State Street (39216)

REFERENCES

1. Kunin, C. M., Zacha, E. and Paquin, A. J.: Urinary Tract Infections in School Children: Prevalence of Bacteriuria and Associated Urologic Findings. New Eng. J. Med. 266:1287, 1962.
2. Kunin, C. M., Deutscher, R. and Paquin, A. J.: Urinary Tract Infections in School Children: An Epidemiologic, Clinical and Laboratory Study. Medicine, 43:91, 1964.
3. Stamey, T. A.: Urinary Infections. Baltimore, The Williams and Wilkins Co., 1972, p. 124.
4. Smellie, J. M., Hobson, C. J., Edwards, D. and Normand, I.C.S.: Clinicla and Radiological Features of Urinary Infection in Childhood. Brit. Med. J. 2:1222, 1964.
5. Stephens, F. D.: Urologic Aspects of Recurrent Urinary Tract Infection in Children. J. Ped. 80:725, 1972.
6. Smellie, J. M.: Medical Aspects of Urinary Infection in Children. J. Roy. Coll. Phy. 1:189, 1967.

"Most of my patients have a sexual fixation," a psychiatrist remarked to his friend. "I'll give you some questions I ask them, just to give you an example. What has smooth curves and is sometimes uncontrollable?"

"A baseball pitcher, of course."

"What wears a skirt and whose lips bring you pleasure?"

"A man who plays a bagpipe."

"Correct! But it's amazing what strange answers some of my patients give me."

Intrathoracic Lymphnodal Hamartoma: A Case Report

ERNESTO CHING, M.D., WILLIAM A. NEELY, M.D., and
CARL G. EVERS, M.D.
Jackson, Mississippi

Lymphoid hamartoma could arise in any soft part of the human body, not infectious nor neoplastic, having features of abnormally developed and organized lymphoid tissue. The authors present a case report of a young woman who had an intrathoracic lymphnodal hamartoma. The patient's history, examination, surgery and gross microscopic studies are discussed.

THE HAMARTOMA has been defined as a benign tumor consisting of an abnormal arrangement of elements which are normal to the tissue where it is found. It may appear anywhere from head to toes, but it occurs more often in certain areas of the body than others. Intrathoracic hamartoma is usually intrapulmonary in location. The extrapulmonary intrathoracic lymphoid hamartoma is rare indeed.

Intrathoracic lymphnodal hamartoma was first reported by Dr. M. R. Abell, a pathologist in Ann Arbor, Michigan, in May of 1957.[1] Although earlier discussion and reported cases might be of the same type of lesion by Castleman, et al in 1956,[2] it may be more proper to classify "Castleman's tumor" as hyperplastic lymphadenitis of mediastinum. The reports of Pemberton, et al[3] and Grimes[4] dealt with cases of giant hemolymph node, which by our present criteria is distinctly different from lymphnodal hamartoma.

A patient who had intrathoracic lymphnodal hamartoma was treated on our thoracic surgery service, and the report follows.

CASE REPORT

A. T., a 20-year-old black female, para I, gravida II, with one abortion, was admitted to the University Medical Center for the first time on Feb. 4, 1973, with a chief complaint of "abnormal chest x-ray revealing a mass in the right lung." She had been seen by her family physician a month earlier for an incomplete abortion which was completed by dilatation and curettage. Routine chest x-ray taken at this time had revealed a mass lesion on the right chest. The rest of the medical history was non-contributory, except that the patient had never had a chest x-ray previously.

Physical examination revealed a well nourished, well developed, cooperative black female who was asymptomatic. Blood pressure was 110/70 both arms; she had a pulse rate of 80 regular, and respiratory rate of 18 and regular. The rest of the physical examination was negative. Her laboratory studies included SMA 4, SMA 12, creatinine, electrolytes and 24-hour urine for catecholamines, all reported as within normal limits.

Chest x-ray revealed a large extrapleural right posterior mediastinal mass (see Figures 1 and 2). Our diagnostic impression at this time was that of mediastinal tumor, probably neurogenic type. The patient was brought to the operating theater on Feb. 7, 1973, and an exploratory right thoracotomy was

From the Departments of Cardiovascular Surgery, Surgery, and Pathology, University of Mississippi Medical Center, Jackson, Miss.



Figure 1. Preoperative chest x-ray.



Figure 2. Postoperative chest x-ray.

carried out. Upon entering the pleural cavity, the lesion could be seen as a 9 x 6 x 4 cm. kidney-shaped tumor mass in the right paravertebral fossa with a pedicle attached from the third to sixth rib posteriorly and extrapleural. This mass was completely excised without difficulty. On gross examination it felt and was shaped like a kidney, but the color was whitish-tan with a definite capsule (see Figures 3, 4, and 5). A frozen section was obtained during the operation which was interpreted as revealing thymoma but subsequent studies established the diagnosis of lymphnodal hamartoma.

GROSS AND MICROSCOPIC STUDIES

The pathologist remarked on the kidney shape of the mass which measured 9 x 6 x 3.5 cm. and weighed 125 gm., the external surface being covered by a capsule which was grayish-white in color. The site of attachment to the chest wall was apparent and measured 6 x 4 cm. (see Figure 3). Upon cutting the capsule one found that there were areas of white, yellowish-white and brownish color (see Figures 4 and 5). Multiple sections of the specimen were taken for microscopic studies. All sections exhibited a monotonously uniform structure with large and small fibrous connective tissue septae, with lymphoid tissue between this supporting stroma (see Figure 6). There were numerous "follicles" with small germinal centers, superficially resembling Hassel's corpuscles (see Figure 7) but without clear-cut epithelial elements, with prominent surrounding concentric lymphocyte cuffing. An occasional area of edema or degeneration was present, with very occasional plasma cells. The final diagnosis was lymphoid hamartoma of thorax.

Lymphoid hamartoma could arise in any soft part of the human body, not infectious nor neoplastic, having features of abnormally developed and orga-

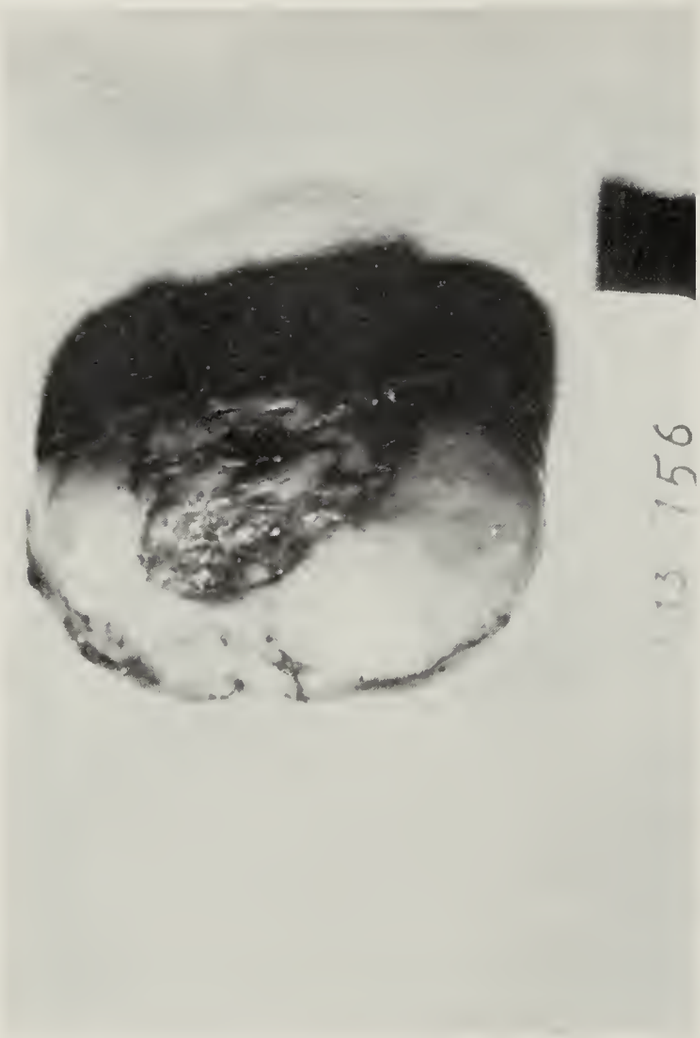


Figure 3. Gross specimen from thoracic cage.



Figure 4. Cut gross specimen.



Figure 5. Close-up view of gross specimen.



Figure 6. Lymph follicles resembling Hassel's corpuscles (microscopic low power).

nized lymphoid tissue. These lesions are essentially asymptomatic and usually present as a mediastinal mass detected on routine chest x-ray and most commonly located in the posterior mediastinum. Grossly, lymphnodal hamartoma is a large, solitary, well circumscribed, smooth and well encapsulated ovoid or kidney-shaped firm mass that may clinically feel like a neurogenic tumor or kidney in consistency. It is light tan in color with fine trabeculation on cut surfaces. Microscopic features reveal normal lymphocytes without evidence of anaplastic changes or "blast" form, arranged in follicles that are evenly distributed throughout the lesion rather than at the periphery alone as in normal lymph nodes. Hassel's corpuscle-like centers resemble the normal thymus gland which in reality are hyalinized lymphoid follicles. Various stages in the transition from relatively normal to markedly hyalinized follicles could be detected. There is absence of inflammatory cells such as plasma cells, eosinophils, histiocytes and some giant cells in lymphoid hamartoma as compared to reactive hyperplastic lymph node; furthermore, adjacent lymph nodes are not enlarged nor do they show evidence of inflammatory response. Hyaline masses of connective tissue are another prominent feature which is absent in normal lymph nodes or in reactive hyperplastic lymph node.

Finally, lymphoid hamartoma differs from giant human hemolymph node in that the latter contains blood in their sinuses instead of lymph. These are believed to be organs *sui generis* by some investigators and are commonly seen in cows or sheep.



Figure 7. Lymph follicles resembling Hassel's corpuscles (microscopic high power).

SUMMARY

An unusual posterior mediastinal tumor in a young lady of 20 is presented. It was initially thought to be the garden variety of neurogenic tumor but subsequently confirmed to be a lymphnodal hamartoma. The close resemblances of this lesion to lymphoma, thymoma, hyperplastic lymph node or hemolymph node was discussed and differential points reemphasized to avoid confusion.

The benign nature of lymphoid hamartoma was pointed out acknowledging that clinically these lesions were entirely asymptomatic, present for a long time with minimal or no evidence of continued growth and total absence of any local recurrence or appearance of disseminated disease despite long-term follow-up. From a pathological standpoint, these lesions are solitary, well encapsulated with benign microscopic features on a cellular level. This case is therefore presented to emphasize the hamartomatous nature of this most interesting tumor rather than of a true neoplasm or of an inflammatory process. ★★★

2500 North State Street (39216)

REFERENCES

1. Abell, M. R.: Lymphnodal Hamartoma Versus Thymic Choristoma of Pulmonary Hilum. A.M.A. Arch. Path. 64:584-588 (November) 1957.
2. Castleman, B., Iverson, L. and Menendez, V.: Localized Mediastinal Lymph-Node Hyperplasia Resembling Thymoma. Cancer 9:822-830 (July-August) 1956.
3. Pemberton, J., Broders, A., and Maino, V.: Giant Hemolymyh Node: Report of Two Cases. Surg. Clinics of N. Am. 30:1147-1153, 1950.
4. Grimes, A.: Giant Hemolymph Node of the Left Chest: Report of Case. J. Thoracic Surg. 31:349-353 (March) 1956.

Advanced Colon Cancer:

Review of 123 Cases at University of Mississippi Medical Center, 1966-1969

JOSEPH STRIBLING, M. P. SMITH, and
GEORGE V. SMITH, M.D.
Jackson, Mississippi

The authors report on 123 patients who were treated for colon cancer between January 1966 and December 1969 at the University of Mississippi Medical Center. In addition, a total of 553 cases of colon cancer and 263 cases of rectal cancer between 1957 and 1970 were studied to determine trends in occurrence. Diagnostic signs and modes and success of treatment are also discussed.

THIS PAPER will represent a review of 123 consecutive cases of colon cancer treated at the University of Mississippi Medical Center between the years 1966-1969 with emphasis on the results of treatment of advanced lesions. As reported by Silverberg and Holleb,[1] cancer is presently the second leading cause of death in the United States. Colon cancer ranks second only to lung cancer in yearly incidence and mortality. In 1972, 55,000 new colon cancers were diagnosed and 36,500 patients died with carcinoma of the colon. In Mississippi there were 600 new cases of colon and rectal cancer and an estimated 375 deaths. Therefore, the figures presented in this study represent about 15 per cent of the cancer cases and deaths in this state. Colon cancer alone killed approximately 270 people in Mississippi in 1972.

This report will compare data from this institution with other centers and suggest means of decreasing morbidity and mortality associated with colon cancer.

The University of Mississippi Medical Center Tumor Registry lists all patients seen in this hospital with cancer and maintains basic information on each case including a yearly follow-up if possible. Between January 1957 and December 1970, 553 patients with colon cancer and 263 patients with rectal cancer were seen. These patients were used to determine trend patterns.

Consecutive charts of 123 patients diagnosed as having colon cancer between January 1966 and December 1969 were reviewed for analysis according to age, sex, race, signs and symptoms, duration of symptoms, location of the tumor, histologic type, treatment, and survival. Excluded from this study are patients seen within the time period under consideration who presented to this hospital initially with a recurrence or with prior treatment in an outside hospital.

Survival is based on three years rather than the customary five year survival period. Krain[2] and others have shown that there is only a slight attrition between three and five years. Observed survival rates are used since cause of death was frequently not reported, or autopsy was not performed on many patients who died at home. Patients dying at surgery, in the immediate postoperative period, or those lost to follow-up (not seen since January 1972) are excluded from this data. There were 20 patients lost to follow-up who were thus excluded but who would have further decreased survival rates had they been included in this study. Male and female survival data is combined in our study, but it is well to note that females have higher survival rates than

From the Department of Surgery, University of Mississippi Medical Center, Jackson, Miss.

males, as is shown by Krain, Eisenberg, and Ederer.[2, 3, 4]

EPIDEMIOLOGIC CONSIDERATIONS

Evaluation with respect to age, sex and race reveals data parallel with the studies of Krain, Eisenberg, and Ederer.[2, 3, 4] The male/female ratio of < 1 demonstrated in this study is more striking than that found in other reports. The Black/White ratio reflects the general population of this hospital with 59 per cent of the patients with colon cancer being Black. Forty per cent of the cases studied were Black females with each of the other sex-race groups composing approximately 20 per cent of the study. The average age at diagnosis was sixty-five years. Ninety-two per cent of these cases were diagnosed in patients older than 50 years.

The incidence of colon cancer in this study period remained fairly constant between 30 and 45 patients per year. A spike to 55 patients for the years 1964-1966 represented a peak. The incidence of rectal cancer also remained constant between 10 and 20 patients each year with an increase to about 25 patients per year between 1958-1963.

When the absolute number of patients is compared to total hospital discharges (a measure of patient population) there is a gradual decrease in colon, rectal, and total colorectal cancers during the study period.

The ratio of colonic to rectal cancer showed much variation, with a relative increase ($> 2:1$) in colon cancers since 1964 as compared to a ratio of $< 2:1$ preceding this year. This finding parallels the report by Lanier, *et al.*[5]

DIAGNOSTIC CONSIDERATIONS

Site. The relative increase in cancers of the right colon noted by Moss[6] between 1940-1959 is verified in this study with an even greater increase, 54 per cent of all colon cancers occurring to the right of the splenic flexure as compared to 42 per cent found by Krain[2] (1945-1966) and 48 per cent by Leichty[7] (1940-1959).

Symptomatology. Three cases were asymptomatic incidental findings at autopsy.

One hundred and eight patients gave a definite date for onset of symptoms. Ten had an onset two to 10 years prior to diagnosis. If these patients are considered, the onset is nearly 10 months prior to diagnosis. If these 10 patients are excluded, the average onset of symptoms is less than five months prior to diagnosis. This agrees with the data of Leichty,[7] *et al.*, who noted a trend toward earlier diagnosis between 1940-1960. However, this earlier diagnosis does not correlate with our finding of more advanced lesions found at surgery in the majority of our patients. This may be due in part to the relatively high incidence of right sided lesions as previously noted as well as to a failure of the patient to accurately recall or note the onset of symptoms.

More than 50 per cent of the patients in this study had significant abdominal pain (68 per cent), constipation (66 per cent), weight loss averaging 27 pounds (63 per cent), or blood loss with the average hemoglobin being 11.0 g/per cent and hematocrit 34.0 per cent (52 per cent). These findings agree with those of Hardy,[8] Cooper and Griffiths,[9] and Keddie and Hargreaves.[10]

Histology and Staging. Ninety-eight per cent of cases have histologic confirmation with 96 per cent adenocarcinomas, two per cent carcinoid tumors, and two per cent diagnosed on clinical grounds (including evidence of metastases). The modified Duke's classification is used for staging. A greater percentage of regional lesions (C_I and C_{II}) are found than was reported by Eisenberg[3] in Connecticut and Norway, and a greater percentage of distant lesions

TABLE I

INCIDENCE OF LESIONS BY STAGES, COMPARATIVE DATA

Lesion	*Univ. Miss. Med. Cen. 1966-69 No. of Cases*	*%*	*Ederer, Connecticut No. of Cases*	*%*	*Eisenberg, Connecticut No. of Cases*	*%*	*Norway*	*%*
Localized	23	19.6	1,131	46	1,263	37	1,008	47
Regional	51	41.0	608	24	867	25	374	18
Distant and unclassified	49	39.4	726	30	1,321	38	752	35
	123	100.0	2,465	100.0	3,451	100	2,134	100

(D) are found when compared to Ederer's[4] report in Connecticut. Combined regional and distant lesions occurred 25 to 34 per cent more frequently than was reported by these men (see Table I). Because of the direct correlation of survival to stage of disease at diagnosis, the survival rate found in our study is expected.

Table II shows the distribution of cancer cases by staging, number of three-year survivals, and percentage of three-year survivals in each stage. The total three-year survival rate (23 per cent) is less than that reported by Krain[2] in California (46 per cent), and Leichty[7] in Iowa (44 per cent) on a three-year basis. Weir[11] reported a 35 per cent five-year survival in Saskatchewan. The survival rates of patients with similar stages are comparable, reflecting a greater percentage of early lesions with longer survival in the other studies. Ederer's[4] results parallel these findings.

Of the deceased patients, average survival after diagnosis dropped from 32 months in Duke's class B, to nine months in class D as shown in Table III.

TABLE III

SURVIVAL FROM DIAGNOSIS BY STAGES IN DECEASED COLON CANCER PATIENTS, 1966-1969

Stage	*Number of Patients*	*Survival (Months)*
B_I	5	32.0
B_{II}	3	5.7
C_I	9	18.2
C_{II}	16	12.4
C_{total}	31	14.8
D	42	8.9
Unclassified	3	2.8

RESULTS OF TREATMENT

Table IV shows the length of survival of 16 untreated patients by classification of the lesions. Survival of untreated patients is severely limited.

Table V shows the results of surgical efforts on survival. While surgery extends the survival of patients who succumb to their disease by only a few months, the greatest success of this mode of treatment is the accomplishment of long-term "cures" for a number of patients. As can be seen in Table V, nearly one-third of the patients who had surgical treatment are still alive or have been lost to follow-up but were long-term survivors (30 months or more in January 1972) when last seen. The best results are in the regionally extensive lesions (C_I and C_{II}), where a greater percentage of long-term survivors occurs when treatment is surgical. Since the bulk of colon cancer patients in this hospital fall into this category, these results are encouraging.

Table VI compares survival in months from diagnosis for patients with no treatment, with surgical treatment, with medical treatment (5-FU) and those with combined medical-surgical treatment. This data is compared with the total average survival by stage regardless of the method of treatment.

Table VI clearly shows that surgery extends life in one-third of the patients treated this way. There is little increase in longevity in the other two-thirds of the patients but the prevention of obstruction, bleeding, perforation or pain by palliative surgery is a very real benefit.

TABLE II

DISTRIBUTION OF COLON CANCER CASES BY DUKE'S CLASSIFICATION, SURVIVORS, AND 3-YEAR SURVIVAL RATE, 1966-1969

Duke's Class	*Number of Cases*		*Number Living*		*3-Year Survival Rate (%)*
A	5	3.9	1	1	100
B_I	11	9.8	3	6	50
B_{II}	7	5.9	2	4	50
C_I	22	17.9	6	14	43
C_{II}	22	17.9	6	19	32
C_{total}*	51	41.0	13	39	33
D	45	36.2	2	42	5
Unclass.	4	3.2	1	4	25
Total	123	100.0	22	96	23

*$C_{total} = C_I + C_{II} + C_{unspecified}$.

SUMMARY

Records of 123 patients with colon cancer between January 1966 and December 1969 at the University of Mississpipi Medical Center were reviewed. Additionally, a total of 553 cases of colon cancer and 263 cases of rectal cancer between 1957 and 1970 were studied to determine trends in occurrence.

Though our data shows an excess of females when compared with studies by other investigators, this probably does not reflect a true difference in susceptibility to colon cancer. The difference is accounted for by the previously unreported finding that there was a predominance of Black females in our study, 40 per cent as compared to 20 per cent for other race-sex groups. Our study corroborates the evidence that colon cancer is a disease of the aged.

There has been a slight decreasing trend in colon and rectal cancer in this hospital since 1964. This could well be explained by an increase in cancer diagnosis and treatment elsewhere in the state by physicians graduated from this University. The relative increase in colonic cancers over rectal cancers seen in this hospital since 1964 could be explained by examining the Medical Center's patient population. Whereas rectal cancer can be more easily diagnosed and treated successfully in early stages, patients with colon cancer may be diagnosed at more advanced stages and referred to this hospital rather than receiving treatment elsewhere in the state. Lanier[5] has also reported a relative increase in colon cancer in Minnesota.

TABLE IV

SURVIVAL OF COLON CANCER PATIENTS WITH NO TREATMENT, 1966-1969

Class	*Number of Patients*	*Survival (Months)*
B_{II}	1	0.0
C_{II}	2	2.0
C_{total}	5	5.8
D	7	1.1
Unclassified	1	0.5
Total	16	2.3

Nearly one-third of colon cancers are found in the appendix, cecum, or ascending colon. The technical difficulties associated with visualizing these lesions on barium enema and the non-emergent symptoms result in diagnosis at more advanced stages of the disease and is especially true of cancers of the cecum.

Previous studies have found approximately 60 per cent of colon cancer cases to be regional lesions or disease with distant metastases. In contrast, the population in this institution with colon cancer presents with more advanced disease as a rule. Nearly 80 per cent of our cases are advanced regional lesions or have distant metastases. The gross survival rate at this institution reflects this finding, with only 23 per cent three-year survival when compared to 46 and 44 per cent three-year survivals reported by other investigators. The survival rate in each of Duke's stages as found here parallels that reported in other studies.

TABLE V

SURVIVAL OF COLON CANCER PATIENTS WITH SURGICAL TREATMENT, 1966-1969

	Deceased		*Alive*	
Class	NO. PTS.	SURVIVAL (MONTHS)	NO. PTS.	SURVIVAL (MONTHS)
A			1	47.0+
B_I			4	39.5+
B_{II}	1	17.0	2	47.5+
C_I	6	19.1	4	53.8+
C_{II}	8	17.5	3	32.7+
C_{total}	17	19.2	7	44.8+
D	15	10.1	1	29.0+
Unclassified	1	7.0	1	60.0+

CONCLUSIONS

Colon cancer is a disease of major importance. Untreated, the disease is fatal, but more sensitive diagnostic methods and surgery in the early course of the disease offer victims hope of long-term cures.

The data presented here applies to only one hospital in the state and deals with only approximately one-seventh of the colon cancers in Mississippi. Reports from other hospitals in the state would be helpful in an attempt to establish a more representative survey of the problem. The establishment of a statewide tumor registry would facilitate a more complete, accurate study of all cancer in the state.

As evidenced by the great preponderance of advanced, metastatic disease seen at this institution, an earlier diagnosis in many more of our patients should be possible. The well established diagnostic signs and symptoms of cancer of the right and left colon would be of use to the state's physicians in raising the index of suspicion for colon cancer, these being:

Cancer of the Right Colon:

1. Unexplained iron-loss anemia.
2. Nausea and/or vomiting.
3. RLQ mass.
4. Fever.
5. Malaise.
6. Anorexia.
7. Weight loss.
8. Change in bowel habits.
9. Change in character of stool, especially melena.

Cancer of the Left Colon:

1. Rectal bleeding.
2. Intermittent constipation and diarrhea.
3. Sensation of incomplete defecation or voiding.
4. Intestinal obstruction.
5. Pain in the abdomen.

While none of these signs are diagnostic in themselves, they should lead the physician to a more extensive examination of the large bowel.

The need for a diagnostic test for the existence of or a recurrence of cancer by determination of the carcinoembryonic antigen (CEA) as reported by Gold[12] exists. This capability assists not only in the diagnosis of colonic cancer but also would be especially important in following the postoperative course of patients, allowing the physician to determine the completeness of surgical removal of the tumor as well as giving early indication of occult recurrence of the disease. This test is still in the developmental stages. Moloney[13] has recently reviewed the status of this test.

The use of the fiberoptic colonscope[14] at the institution has been helpful in some cases and should be a part of the diagnostic armamentarium of any institution attempting sophisticated colon cancer diagnosis and follow-up care.

With the newer diagnostic methods and the possibility of earlier diagnosis by mass screening and greater public information, the number of advanced cases of colon cancer seen here should begin to decline. The surgical treatment of early lesions greatly reduces the mortality and morbidity associated with colon cancer and its treatment as well as producing long-term cures for this disease, while radical surgery for advanced lesions does not compensate for delay in diagnosis. ★★★

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TABLE VI

SURVIVAL OF COLON CANCER PATIENTS WITH NO TREATMENT, WITH SURGERY, WITH 5-FU, AND WITH SURGERY+5-FU, 1966-1969

Class	*No Treatment* NO.	MONTHS	*Surgery* NO.	MONTHS	*5-FU* NO.	MONTHS	*Surgery+5-FU* NO.	MONTHS	*Average All Pts.* MONTHS
				Deceased Patients					
A									
B_I	1	0.0					1	26.0	32.0
B_{II}			1	17.0					5.7
C_I			6	19.1			3	27.0	18.2
C_{II}	2	2.0	8	17.5	1	1	5	9.0	12.4
C_{total}	5	5.8	17	19.2					14.8
D	7	1.1	15	10.1	4	3	16	12.9	8.9
Unclass.	1	0.5	1	7.0					2.8
				Living Patients					
A			1	47.0+					
B_I			4	39.5+					32.0
B_{II}			2	47.5+					5.7
C_I			4	53.8+					18.2
C_{II}			3	32.7+			2	44.5+	12.4
C_{total}			7	44.8+					14.8
D			1	29.0+					8.9
Unclass.			1	60.0+					2.8

REFERENCES

1. Silverberg, E. and Holleb, A. I.: Cancer Statistics, 1972. Ca. Can. J. for Clinicians 22:2-20 (January, February) 1972.
2. Krain, L. S.: Cancer of the Colon in California, 1945-66: The California Tumor Registry Experience. J. Surg. Oncology 2 (4):323-334, 1970.
3. Eisenberg, H., et al: Cancer of the Large Intestine and Rectum: Comparative Data From Connecticut and Norway, 1953-58. National Cancer Institution Monograph (Oct. 19) 1968.
4. Ederer, F., et al: Survival of Patients With Cancer of the Large Intestine and Rectum, Connecticut, 1935-54. J. Natl. Can. Inst. 26:489-95, 1961.
5. Lanier, A. P., et al: Colorectal Cancer in Rochester, Minnesota 1940-69. Cancer 31:606-615 (March) 1973.
6. Moss. N. H.: Cancer of the Colon and Rectum. Proc. 5th Natl. Can. Conf. 627-33, 1964.
7. Liechty, R. D., et al: Adenocarcinoma of the Colon and Rectum: Review of 2,261 Cases Over a 20 Year Period. Dis. Colon Rectum 11:201-8, 1968.
8. Hardy, J. D.: Cancer of the Lower Left Colon and Rectum: Current Status. Pa. Med. J. 10:613-18, 1959.
9. Cooper, J. and Griffiths, J. D.: Carcinoma of Colon and Rectum. Lancet 2:873 (October 19) 1968.
10. Keddie, N. and Hargreaves, A.: Symptoms of Carcinoma of the Colon and Rectum. Lancet 2:749-50, (October 5) 1968.
11. Weir, J. A.: Cancer of the Colon in South Saskatchewan. Cancer 31:616-620 (March) 1973.
12. Gold, P.: Circulating Antibodies Against Carcinoembryonic Antigens of the Human Digestive System. Cancer 20:1663-67, 1967.
13. Moloney, J. P.: Carcinoembryonic Antigen. Med. J. Aust. 2:91-97 (July 8) 1972.
14. Overholt, B. F.: Flexible Fiberoptic Sigmoidoscopy Technique and Preliminary Results. Cancer 28:123-26, (July) 1971. (The First National Conference on Cancer of the Colon and Rectum.)

Bothered with hay fever, a pretty teacher took two handkerchiefs to a dinner party, one of which she stuck in her bosom. During the meal, she began rummaging to right and left in her blouse for the fresh handkerchief. She suddenly realized that conversation had ceased and the guests were watching her, fascinated. In confusion she murmured, "I know I had two when I left home."

Maternal Mortality in Mississippi: 1970-1971

WILLIAM B. WIENER, M.D.
Jackson, Mississippi

A summary is presented of data obtained by the Committee on Maternal and Child Care from its study of maternal deaths in Mississippi in 1970 and 1971. The author reviews the committee's methods of study and the results found. He notes that although the maternal death rate in Mississippi for both white and nonwhite continues to decline, it still greatly exceeds the U. S. maternal death rate.

Analysis of deaths occurring in women during or within 90 days after pregnancy is of continuing value in pointing up ways in which this tragic loss of life can be reduced. The Committee on Maternal and Child Care of the Mississippi State Medical Association has recently compiled its study data for the calendar years 1970 and 1971. The present report completes the 16th annual study by the committee on maternal deaths occurring in Mississippi. Data collected in a similar manner as before are presented and compared, when appropriate, with those for prior years.

Preliminary data from the Mississippi State Board of Health indicates that in 1971 there were 21 maternal deaths. This compares to 34 maternal deaths in 1970. The number of live births in the state totaled 48,141 in 1970 and 48,601 in 1971. Thus the maternal mortality rate (maternal deaths per 10,000 live births) declined from 7.0 in 1970 to 4.3 in 1971. This represented a white maternal mortality rate of 2.0 for each year and a decline in the nonwhite maternal mortality rate from 12.4 to 6.8. Preliminary data indicate that the maternal mortality rate for the United States in 1971 was 2.1 and 2.4 in 1970.

The committee studied 14 maternal deaths occurring in 1971 and 20 maternal deaths occurring in 1970. There was a significant increase in the percentage of usable replies received to the committee's inquiries in 1971 (see Table 1). All replies are evaluated according to their adequacy on a scale from 1 (low) to 5 (high) (see Table II). In order to achieve the latter rating the data sheet for the committee's study has to be completely filled out, a relevant explanatory note attached, and an autopsy report included, if available. Cases rated 1 or 2 are often difficult to evaluate because of the scanty nature of the information. The overal quality of the replies received in 1971 was considerably better than in 1970.

Following the AMA "Guide for Maternal Death Studies" the committee classifies maternal deaths as either being direct obstetric deaths or indirect obstetric deaths. Direct obstetric deaths are defined by the Guide as those in which the cause of death is due to a condition directly related to the pregnancy such as hemorrhage, toxemia, infection, anesthesia, or vascular disease. Indirect obstetric deaths are those resulting from disease present before or developing during pregnancy which was not a direct effect of the pregnancy but was obviously aggravated by the physiological effects of the pregnancy and caused the death.

The proportion of deaths considered to be due to the complications of pregnancy itself (direct obstetric deaths) was slightly lower in 1971 when compared to 1970 (see Table III). The cases in which the cause of death could not be determined illustrate the difficulty that the committee has when information is scanty or when the physician has

TABLE I

STUDY MATERIAL

	1970		1971	
	No.	Per Cent	No.	Per Cent
Total cases	29		16	
Replies received	21		14	
Replies usable	20	68.96	14	87.5

Chairman, Committee on Maternal and Child Care.
Committee members—William R. Eure, M.D., Bay Springs; W. E. Godfrey, M.D., Natchez; George J. Nassar, M.D., Greenwood; K. Ramsay O'Neal, M.D., Hattiesburg; William B. Wiener, M.D., Jackson; Wendell H. Stockton, M.D., Amory. Consultants—Catherine G. Goetz, M.D., Jackson (Pathology); Alvin E. Brent, Jr., M.D., Jackson (Internal Medicine); Curtis W. Caine, M.D., Jackson (Anesthesiology).

TABLE II

ADEQUACY OF DATA

Category	1970 No.	1970 Per Cent	1971 No.	1971 Per Cent
5	5	25.0	0	
4	4	20.0	3	21.5
3	1	5.0	9	64.3
2	5	25.0	1	7.1
1	5	25.0	1	7.1

seen the patient only for a short time before death or even after death.

TABLE III

CAUSES OF DEATH

	1970 No.	1970 Per Cent	1971 No.	1971 Per Cent
Direct obstetric	17	85.0	11	78.6
Indirect obstetric	2	10.0	2	14.3
Undetermined	1	5.0	1	7.1

Among the direct obstetric deaths, the percentage due to hemorrhage remained rather constant during the two years studied (see Table IV). In 1957, the first year the committee conducted its studies, 59.2 per cent of the direct obstetric deaths was due to hemorrhage. Deaths due to toxemia also remained rather constant during the period studied. Data sheets on these patients during all years of the committee's study often reveal one of two difficulties. Either the treatment of the patient with severe pre-eclampsia or eclampsia was not vigorous enough, especially in the reluctance to induce labor, or convulsions or death occurred while the patient was under observation, indicating a lack of awareness on the part of hospital personnel that these patients are critically ill and require constant attention.

TABLE IV

CAUSES OF DIRECT OBSTETRIC DEATHS

	1970 No.	1970 Per Cent (of all deaths studied)	1971 No.	1971 Per Cent (of all deaths studied)
Hemorrhage	8	47.1	4	36.4
Toxemia	6	35.3	4	36.4
Infection	1	5.9	3	27.2
Vascular accidents	0		0	
Anesthesia	0		0	
Other	2	11.7	0	

In an effort to assist physicians and hospital personnel in handling difficult obstetric cases, the committee has prepared and distributed "Maternal Care Desk Cards." These cards are presently being revised by the committee and a new distribution will be made within the next few months.

The percentage of deaths considered avoidable by the committee was about the same in both years studied (see Table V). Avoidable factors are arbitrarily assigned to the physician, hospital or patient (see Table VI).

TABLE V

AVOIDABILITY

	1970 No.	1970 Per Cent	1971 No.	1971 Per Cent
Avoidable	18	90.0	12	85.8
Non-avoidable	1	5.0	1	7.1
Undetermined	1	5.0	1	7.1

TABLE VI

AVOIDABLE FACTORS

	1970 No.	1970 Per Cent	1971 No.	1971 Per Cent
Professional	12	50.0	9	56.3
Hospital	1	4.2	1	6.2
Patient	9	37.5	6	37.5
Undetermined	2	8.3	0	37.5

TABLE VII

MATERNAL DEATH RATE PER 100,000 LIVE BIRTHS

	1970	1971
Mississippi*	70.6	43.2
U.S.	24.7	20.5

* Based on Mississippi State Board of Health Statistics showing 34 maternal deaths in 1970 and 21 maternal deaths in 1971.

SUMMARY

1. Thirty-four maternal deaths occurring in Mississippi during the period 1970-1971 have been studied by the Committee on Maternal and Child Care.

2. Although the maternal death rate in Mississippi for both white and nonwhite continues to decline, it still greatly exceeds the U. S. maternal death rate.

3. Plans are underway to revise and redistribute the committee's "Maternal Care Desk Cards." ★★★

500-G East Woodrow Wilson Dr. (39216)

Radiologic Seminar CXXXVII: The Pseudofractures of Osteomalacia

JOHN Y. GIBSON, M.D.
Jackson, Mississippi

OSTEOMALACIA is a disorder of bone resulting from insufficient mineralization of bone matrix (osteoid). The production of normal bone requires both the formation of a proper amount of osteoid and the sufficient calcification of the osteoid. In osteomalacia the quantity of osteoid is normal, yet the mineralization of the osteoid is deficient. This condition should not be confused with osteoporosis in which the amount of osteoid is deficient but the mineralization process is normal.

Pseudofractures frequently occur in osteomalacia. Their significance as an expression of a specific disorder was first recognized by Louis A. Milkman,[1, 2] a Pennsylvania radiologist, and the form of osteomalacia in which they occur is sometimes referred to as Milkman's syndrome. Pseudofractures are band-like zones of demineralization which extend into bone perpendicular to the cortical margin. In this radiolucent band the osteoid has formed normally but has not been sufficiently calcified. They are sometimes called "zones of looser" or "umbauzonen" (zones of transformation). Pseudofractures are often bilateral and symmetrical (see Figure 1) and occur most frequently at the axillary border of the scapula (see Figures 2 and 3), the medial border of the femoral neck, the ribs (see Figure 4) and the ischial and pubic rami. They may also occur in the iliac bones, the radius and ulna and the tibia and fibula. While the explanation for these sites of predilection remains controversial, Steinbach has offered an interesting theory.[3] He has called attention to the close relationship of blood vessels to these sites and proposed that pseudofractures are a result of an erosion of the softened cortex by constant pressure from the adjacent vessels. The pseudofractures of osteomalacia will usually heal following therapeutic measures to increase the body stores of calcium and phosphorus. The patient whose radiographs are reproduced in this article was treated with high doses of vitamin D and the pseudofractures healed completely.

Other conditions in which pseudofractures occur are Paget's Disease, fibrous dysplasia and osteogenesis imperfecta. However, the pseudofractures in these conditions differ from those in osteomalacia in the following ways: they occur at the sites of obviously abnormal bone which is often deformed to a considerable degree; they are not bilateral and symmetrical; they do not appear at characteristic sites of predilection and they heal without benefit of therapy to increase body stores of calcium and phosphorus.[3] ★★★

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Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, Miss.

REFERENCES

1. Milkman, L. A.: Pseudofractures (Hunger Osteopathy, Late Rickets, Osteomalacia). Amer. J. Roentgenol. 24:29-37, 1930.
2. Milkman, L. A.: Multiple Spontaneous Idiopathic Symmetrical Fractures. Amer. J. Roentgenol. 32:622-634, 1934.
3. Steinbach, H. L., Kolb, F. O. and Gilfillan, R. S.: Mechanism of Production of Pseudofractures in Osteomalacia (Milkman's Syndrome). Radiology 62:388-394, 1954.
4. Steinbach, H. L. and Noetzli, M.: Roentgen Appearance of the Skeleton in Osteomalacia and Rickets. Amer. J. Roentgenol., Rad. Therapy & Nuclear Med. 91:955-972, 1964.
5. Edeiken, J. and Hodes, P. J.: Roentgen Diagnosis of Diseases of Bone. Baltimore, Williams & Wilkins Co., 1967, p. 6.171-6.174.

ADDENDUM: The editors note with regret that the x-ray photographs in Dr. Clyde R. Allen's radiologic seminar appearing in the February issue of the JOURNAL (p. 56-57) were inadvertently transposed. Our sincere apologies go to Dr. Allen for this error.



Figure 1. Pseudofractures in both scapulae (arrows).



Figure 2. Close-up view of radiograph in Figure 1. Arrows on each side of pseudofractures at acromian process of right scapula.



Figure 3. Close-up view of radiograph in Figure 1. Arrows on each side of pseudofracture at axillary border of left scapula.



Figure 4. Pseudofracture of 10th rib (arrows).



The President Speaking

"A Chaplet of Grace"

ARTHUR A. DERRICK, JR., M.D.
Durant, Mississippi

I HAVE JUST returned from my 35th class reunion. The old crew seems to be holding up pretty well. A little grayer, a little paunchier, but all still active in the practice of medicine. Amongst the expected nostalgic reminiscences, one subject kept cropping up. I realize how easy it is for the older generation of doctors, plumbers or anything else to express their doubts, with the proper head-shaking, of course, as to the objectives, the dedication, the sacrifices, the diligence of the younger generation of doctors, plumbers or anything else! Nevertheless, that was exactly what kept on being expressed by this bunch of "old Turks," who used to be "young Turks!" Many examples were cited by my classmates, who range from board-certified chiefs down to lowly country practitioners (me!). Unfortunately, no one had any pat answers to this dilemma—theories, yes, in wide variety, but nothing definite. We all realize that times do indeed change, in medicine as in everything else, and we know with Thomas Wolfe that "you can't go home, again," but along with the massive gains in technology and ability, must we not guard against the depersonalization of medical care, which I feel is the basic cause of all that head-shaking.

To quote from Proverbs, "Wisdom is the principal thing; therefore get wisdom: yea, with all thou hast gotten get understanding."

The "wisdom" is there in amazing quantity and can be stored in banks of computers, but to use this knowledge, and apply it properly in the care of the sick, the catalyst is "understanding," a huge basket of a word, that contains all our desires, our intentions, our hopes and our dreams. Should it not be planted, nourished and cultivated in all who choose this great profession. Then, as King Solomon said, "She shall give to thine head a chaplet of grace." ★★★

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EDITORIALS

An Analysis of the Phase IV Price Regulations

On Jan. 16, 1974, the Cost of Living Council published its final Phase IV price regulations for the health care industry. The adoption of these regulations by the COLC was not without protest, however, as both the AMA and MSMA issued strong appeals for removal of price controls on the medical profession; but pleas from every sector of health care fell on deaf ears. The Phase IV regulations are now final and with their publication the AMA has expressed its intention of filing suit against the COLC to enjoin its continued enforcement of price controls on the medical profession.

So the battle continues, but in the meantime all physicians must comply with Phase IV rules since they have the force of law. Hopefully, this explanation of the regulations will provide the requisite understanding necessary for the consideration of any proposed fee change.

The effective date of the new regulations is Jan. 1, 1974, and any fee increased on that date or thereafter will have to satisfy the regulations unless it is an accumulated increase from prior years as will be further discussed. If a physician's books are kept on other than a calendar year basis, then he would be subject to the *old* rules until his fiscal year ends. As such he would not be subject to the *new* rules until his fiscal year begins. A practice whose fiscal year ends on June 30, for example, would apparently not come under the *new* rules until July 1, 1974.

If a physician has not increased his fees by the allowable 2.5 per cent per year in 1972 and 1973, then he may carry the unused percentage over to 1974 although such a delayed increase would be considered under the *old* rules. Therefore, a physician who has not raised his fees at all during 1972 and 1973 can raise them after Jan. 1, 1974, to the extent that the increase satisfies all three of the following old requirements: (1) The increase will not increase the practice's gross income by more than 5 per cent; (2) The increase will not cause the practice's profit margin to be greater than its base period profit margin; and (3) The increase will not be greater than the increase in "allowable costs," or all practice expenses, since the last fee increase on Jan. 1, 1971.

Any such increase in 1974 is still subject to one further requirement. No individual fee for any service may be increased by more than 10 per cent; if the fee was less than $10 before the change, then it may be increased by $1 even though that would be more than a 10 per cent increase.

The new fee increase regulations will also be cumulative; therefore, the basic 4 per cent limitation for 1974 could be passed up in 1974 so that a physician could increase his fees by 8 per cent in 1975, etc.

Just as with the *old* regulations, physicians under the new rules will have to satisfy three separate limitations in order for a proposed 1974 increase to be proper. These three *new* limits are: (1) No individual fee may be increased by more than 10 per cent except that a fee of $10 or less may be increased by $1. (2) No fee may be increased so it would result in an "aggregate weighted price increase" of more than 4 per cent per year over that of the prior year; and (3) No fee increase may increase the

practice's "revenue margin" measured after the increase over the revenue margin for the base period."

The first requirement was discussed earlier, but to reiterate it simply means that the fee for a service or procedure cannot be increased by more than 10 per cent unless the procedure is $10 or less, in which case the increase may be $1. Thus, any fee of $10 or less, such as office visits or lab procedures, can be increased only $1 while any fee greater than $10 can be increased by only 10 per cent.

The second new limitation changes the old 2.5 per cent rule to the extent that the "aggregate weighted price" cannot be increased by more than 4 per cent per year because of a fee increase. In the COLC's belated attempt to simplify this requirement, they have promulgated the following formula for calculating the increase percentage:

$$\% \text{ AWPI} = \Sigma \frac{P_2 - P_1}{P_1} \times \frac{B_1}{B_2} \times 100$$

A breakdown of this formula shows its elements relate to the following:

P_1 = The customary price lawfully in effect on the last day of the immediately preceding fiscal year for a service or property.

P_2 = The highest customary price charged or to be charged during the current fiscal year for that service or property.

B_1 = The actual gross billings during the immediately preceding fiscal year for that service or property.

B_2 = The total gross billings during the immediately preceding fiscal year for all services or property.

Σ = The sum of.

In applying this formula to your own proposed fee increases, perhaps these two examples will help:

A. Dr. A (or Group A) wants to increase his fee for office visits from $10 to $11 on Jan. 1, 1974. For calendar year 1973 (that being his fiscal year), there had been 5,000 office visits and total billings were $110,000. All fee increases under the old 2.5 per cent per year rules had been adopted. The increase would not be permissible because the formula would show:

$$\frac{\$11 - \$10}{\$10} \times \frac{5{,}000 \times \$10}{\$110{,}000} \times 100 = 4.5 \text{ per cent}$$

B. Dr. B (or Group B) wants to increase his fee for normal deliveries from $300 to $325 on the first day of his professional corporation's next fiscal year which will be Feb. 1, 1974. For the fiscal year ending Jan. 31, 1974, there were 200 such deliveries and the total practice billings were $132,000. All prior allowable increases had been taken. The increase would be permissible under the following calculation:

$$\frac{\$325 - \$300}{\$300} \times \frac{200 \times \$300}{\$132{,}000} \times 100 = 3.8 \text{ per cent}$$

This new rule has several important features. First, increasing a fee on the first day of the new year would be next to impossible unless a physician had immediate access to bookkeeping figures for the year he has just completed. In addition, he must have accurate records as to the number of times each service is provided. On the other hand, the new 4 per cent rule can be calculated with some accuracy since it is based on the prior year's business records as opposed to the old 2.5 per cent rule which was based on projections of work patterns in the year following the fee increase, thus necessitating hit-and-miss guesswork.

Lastly, the new regulations base the test on billings for services rather than on collections. This can prove difficult for poorly managed practices which fail to record changes or accumulate them into periodic totals.

The third new limitation is essentially the same as the "profit margin limitation" under the old regulations—the physician's profit or revenue margin cannot become higher as a result of the fee increase. The definition of "revenue margin" is essentially unchanged from that of the old "profit margin" which is a practice's net income after expenses divided by its total receipts.

As might be expected, the new rules require the physician to have a schedule of his fees available. In addition, each physician must again dust off and post his sign stating that his fee schedule is available and where it may be obtained. This schedule will have to reflect the fees in effect on Oct. 1, 1973, for all those items which comprise 90 per cent of total revenues.

The Cost of Living Council has stated that the new regulations simplify the fee control system as it applies to medical practices although a close examination reveals that they appear to have the opposite effect. On top of all this, President Nixon recently indicated that the administration will not request the continuation of price controls on any sector of the economy except health and petroleum when Congressional authority for such controls expires later

this year. It is disheartening indeed, and one can only hope that either the AMA will have its day in court or the Congress, in its wisdom, will allow price controls to end for the health care field.

WILLIAM F. ROBERTS, J.D.
Executive Assistant, MSMA

Weinberger Condemns Medicare and Medicaid Patients to Second-Class Medicine

This editorial is *significant* and should be *of interest* to all practitioners as total (government sponsored) national health care approaches. We should stop to consider all aspects.

In the final analysis pharmaceutical manufacturers operate under our free enterprise system with a keen desire to maintain their reputations based to a large extent on physician and patient acceptance.

As investment stocks their performance is not spectacular —so they are not getting rich at the expense of the sick.

It is conceivable to this writer that if the trend continues, their greatest effort could be toward bureaucratic approval rather than patient well being.

W. MONCURE DABNEY, M.D., Editor

Private Practice, the journal of socioeconomic medicine published by the Congress of County Medical Societies, has announced its total opposition to the recently announced drug plans of the Department of Health, Education and Welfare. As outlined by Secretary Caspar W. Weinberger, HEW would limit reimbursements for prescription drugs provided under Medicare and Medicaid to "the lowest cost at which the drug is generally available." This would usually be the so-called generic drug rather than a brand-name pharmaceutical.

Testifying on December 19 before Senator Edward Kennedy's Senate Health Subcommittee, Mr. Weinberger claimed that this would save taxpayers $25 to $60 million between now and the fiscal year ending June 30.

"We deplore this kind of cheap-drug policy," said Publisher Francis A. Davis, M.D. "It condemns Medicare and Medicaid patients to second-class medical care. The whole notion is based on the mistaken idea that chemical equivalency equals therapeutic equivalency. There are many reasons why this is not so. This kind of short-sighted policy, while it *may* save some money in the short run, will do so only at a very high cost to the health of American people."

Writing in *Private Practice,* William H. Havener, M.D., of Columbus, Ohio, has noted that:

"The concept of generic prescribing may be defined as the belief that identification of a drug by its chemical name is accurate and sufficient for medical purposes.

"Generic prescribing is of current legislative interest because of the belief that great economy is possible through the purchase of an accurately named chemical (a generic equivalent) instead of a brand-name medication.

"Certainly all sensible taxpayers want economy in government, including money spent on health care.

"However . . . the medical profession opposes legislation directing that the least expensive generic equivalent shall be substituted in the filing of a medical prescription.

"How can this apparently inconsistent position be justified?

"The basic fact is that generic equivalence is a myth.

"I will cite an illustration of this myth which will be familiar to everyone, then will discuss the problem from a medical standpoint.

"First, let us specify a substance by the accurate generic name 'carbon.' What do we mean? It could be a polished diamond or a chunk of coal. They are generic equivalents, but they are certainly not the same.

"Since I am an ophthalmologist, I shall use eye drops to illustrate why the concept of generic equivalence is a myth. Let us assume that the name and concentration of a chemical have been designated. Are all eye drops the same if they contain this amount of the chemical?

"Let me outline a few other things that matter before you put this eyedrop in your eye:

"A. pH (acidity or alkalinity)

"1) Determines degree of dissociation of alkaloids and therefore their availability to penetrate the eye.

"2) Related to stability, i.e., how long till it deteriorates and is unusable.

"3) Important factor in comfort—whether the drops hurt.

"B. Sterility

"Use of unsterile generic equivalent during eye surgery could destroy eye through infection.

"C. Preservatives

"A variety of chemicals in various concentrations may be added to help retard growth of bacteria. Preservatives may have toxic effects to the eye, improve or hinder absorption of the drug, and are of variable

effectiveness. Many incompatibilities exist, in which the preservative may inactivate the medication.

"D. Particle size (of suspension)

"Larger particles offer less available drug, sediment out of suspension, and may be mechanically irritating.

"E. Choice of salt

"The active drug may be combined with a variety of ions, i.e., pilocarpine hydrochloride, nitrate, or salicylate. Each has different incompatibilities and solubilities.

"F. Antioxidants and stabilizers

"Addition of appropriate substances will greatly extend the expiration date of unstable compounds. Conversely, their absence permits rapid deterioration.

"G. Viscosity

"A viscous vehicle will greatly prolong contact of the eye-drop with the eye. Some types dry to a protective film on the eyelids and are unusually effective in treatment of lid infections. Other vehicles may be greasy and can be cosmetically or functionally objectionable.

"H. Solubility relationships

"A medication form which is more soluble in the vehicle than in the corneal surface will stay in the vehicle and will not be optionally absorbed by the eye.

"I. Wetting agents

"Detergent-like additives can greatly enhance drug penetration.

"J. Combinations

"Mixtures of active drugs may give an improved effect or have advantages of convenience or economy. They also increase the chance of allergy or other toxicity.

"K. Drug form

"Choice of suspensions or solution may have advantages of stability or penetration of the medication.

"L. Tonicity

"Hypertonic or hypotonic solutions may irritate or even destory the delicate cells of the eye. I have seen blindness result from irrigation of the interior of the eye with solutions of improper salt concentration.

"M. Packaging

"Various containers have advantages of ease of use, breakage resistance, spill-proofing, chemical inertness, size economy, protection from light, etc.

"Medications other than eye drops also have different vehicles:

"A. Taste, smell, color, consistency are important in determining the acceptability of the medication to the patient. Will the child (or adult) take his medicine?

"B. Purity may vary greatly. U.S.P. requirements specify 85 percent purity for penicillin. Many reputable manufacturers achieve 98 percent purity. 'Penicillin' allergy is often due to impurities.

"C. Coating of capsules may protect medication against destruction by stomach acids. Prolonged medication effect is achieved by mixtures of granules with coating which will dissolve at various rates. Faulty coatings may not dissolve at all, permitting the pill to pass through the body with no medical effect at all.

"D. Absorption of medication from pills depends on how rapidly they dissolve, the choice of salt used, the stability of the drug in digestive juices, whether it becomes absorbed upon food residues, and a variety of other such factors. As a well recognized example, Chloromycetin (Parke-Davis brand name) is a very effective antibiotic, whereas all other generic equivalents of chloramphenicol (generic name) fail to achieve comparable blood levels of the antibiotic.

"E. Deterioration to ineffective or toxic substances may occur. Tetracycline (an antibiotic) dispensed in relatively acid capsules will slowly transform into a deadly kidney poison. Without appropriate (and costly) safeguards, problems do occur."

Because the medical effect of a given chemical is so greatly dependent upon the form in which it is dispensed, the concept of "generic equivalence" is truly an imaginary oversimplification.

" 'There exists hardly anything that some unscrupulous man cannot make a little more poorly and sell a little cheaper.

" 'Long after the joy of low price passes, the bitterness of low quality remains.'

"It is understandable, but tragic," concluded Dr. Davis, "that Secretary Weinberger has chosen to believe that the cheapest drug product on the market would perform as well as the most expensive one. He has applied a concept to the health of Medicare and Medicaid patients that he would rightly hesitate to use with meat, Scotch, or golf balls."

Llewellyn H. Rockwell, Jr.
Private Practice
3035 N.W. 63rd—Suite 299
Oklahoma City, Okla. 73116

LETTERS

SIRS: The American Medical Association is pleased to announce the opening of nominations for the 1974 Dr. Rodman E. Sheen and Thomas G. Sheen Award.

Consisting of a $10,000 cash prize and a commemorative plaque, the Sheen Award is presented annually to an American physician or physicians in recognition of outstanding contributions in medicine. It is made possible by a bequest in the will of the late Thomas G. Sheen, a businessman in Atlantic City, N. J., and is administered by the Guarantee Bank and Trust Company of Atlantic City, trustees of the estate of Thomas G. Sheen.

The Sheen Award was first bestowed in 1968. Previous recipients were Drs. Irvine H. Page, Cleveland; Robert E. Gross, Boston; Charles B. Huggins, Chicago; Maxwell Finland, Boston; Paul Dudley White, Boston; and William Bosworth Castle, Boston.

Nominations will be accepted from state and local medical societies, medical specialty societies, medical research organizations, medical schools, hospital medical staffs, and public health agencies at all levels of government, and other appropriate military or civilian agencies. Nominations for the annual award will be received in writing by a committee of physicians named by the Board of Trustees of the American Medical Association. The committee will examine each nomination, and recommend to the Trust Officers of the bank the recipient or recipients of the award. The award is bestowed each year at the Annual Convention of the American Medical Association. The recipient must be present to accept the award, or forfeit eligibility.

Candidates must be United States citizens and must possess an M.D. degree. The award can recognize either a single achievement or an accumulated career of excellence. The outstanding contributions to medicine for which Sheen Award recognition is proposed need not have occurred in the United States.

Written nominations are being accepted through Mar. 15, and should be sent to: The Sheen Award Committee, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

Candidates for the award will be evaluated by the committee and recommendations will be made to the Board of Trustees of the American Medical Association. Final selection of the 1974 recipient will be made by the Trust Officers of the Guarantee Bank and Trust Company of Atlantic City.

The 1974 award will be presented June 23, during the Annual Convention of the American Medical Association in Chicago.

LYNN M. THOMAS
Secretary
The Sheen Award Committee

DEATHS

BLAINE, JAMES G., Hazlehurst. M.D., Tulane University School of Medicine, New Orleans, La., 1935; interned US Marine Hospital, Stapleton, N.Y., one year; died Jan. 21, 1974, age 68.

EDDLEMAN, THOMAS S., Jackson. M.D., Medical College of South Carolina, Charleston, South Carolina, 1935; interned Roper Hospital, Charleston, S. C., one year; surgery residency, same, one year; orthopaedic surgery residency, Campbell Clinic, Memphis, Tenn., 1937-1940; died Jan. 9, 1974, age 68.

EDWARDS, BOYD C., Jackson. M.D., Tulane University School of Medicine, New Orleans, La., 1931; interned Touro Infirmary, New Orleans, La., one year; vice president of Central Medical Society, 1950; died Feb. 4, 1974, age 73.

ROTENBERRY, C. G., Mendenhall. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1943; interned Knoxville General Hospital, one year; died Jan. 11, 1974, age 55.

WILSON, THOMAS E., JR., Jackson. M.D., University of Virginia Medical School, Charlottesville, Va., 1928; interned, same, one year; internal medicine residency, Blue Ridge Sanatorium, Charlottesville, Va., one year; medicine residency, House of Good Samaritan, Boston, Mass., one year; served as president of the Ole Miss Medical Alumni, 1966-67; secretary, Central Medical Society, 1946; president, 1949; died Jan. 20, 1974, age 73.

PERSONALS

Donald Berry of Picayune has been elected Chief of Staff of the Lucius Olen Crosby Memorial Hospital medical staff.

W. Joseph Burnett announces the opening of his office for the practice of ear, nose and throat, head and neck surgery and facial plastic surgery at Oxford-Lafayette County Hospital in Oxford.

Magruder Corban of Gulfport was named temporary chairman of a newly-organized movement to establish an ambulance district covering West Harrison and the east portions of Hancock counties.

Paul Derian of UMC attended a meeting of the Academy of Orthopedic Surgeons in Dallas.

Marshall G. Edmonson announces the opening of his office for the practice of family medicine at 820 Second Avenue North in Columbus.

Paul Edwards announces the opening of his office for the practice of medicine in the Columbus Hospital.

Norman A. Garrison, Jr., announces the opening of his office for the general practice of medicine at Magnolia Doctors Plaza in Corinth.

Jan T. Goff has assumed his new duties as medical director of the Regional Mental Health Complex, North Mississippi Medical Center in Tupelo. Dr. Goff was formerly senior instructor in psychiatry at the St. Louis University School of Medicine.

Edward Gore of Houston was presented the Outstanding Young Man Award by the Houston Jaycees at their annual banquet.

James D. Hardy of UMC attended the American Surgical Association's president's dinner in Nashville recently.

Romeo Hernandez and Meta Hernandez have opened their clinic in Tylertown for the practice of general surgery and family medicine.

Jack C. Hoover and Thomas R. Singley announce the relocation of their offices to Doctors Plaza, Suite 208, Hospital Road in Pascagoula for the practice of obstetrics and gynecology and infertility.

Michael Jabaley of UMC participated in the annual meeting of the American Society for Surgery of the Hand held in Dallas during January.

Hansel Janet of Biloxi was honored as doctor of the month during the monthly meeting of the Ninth District of the Mississippi State Pharmaceutical Association in Biloxi.

William L. Jaquith of Whitfield was recently presented the Golden Deeds Award of the Leavell Woods Exchange Club of Jackson. Dr. Jaquith was cited for being "an outstanding member of the community with sacrifices and achievements that often go unsung."

Samuel B. Johnson of Jackson has moved his offices to the Addie McBride Rehab Building at 2500 N. State Street for the practice of ophthalmology.

Charles W. Krieger has opened his office in Picayune at 310 North Main Street for the practice of orthopedic surgery.

William B. C. Lobrano has associated with Louis A. Rubenstein and Ben E. Kitchens for the practice of family medicine at the Spring Plaza Shopping Center in Ocean Springs.

Fred L. McMillan announces the opening of his office for the practice of ophthalmology, Suite 617, Medical Arts Building, 1151 North State Street in Jackson.

Norman Nelson of UMC spoke at the monthly luncheon meeting of the Vicksburg Rotary Club.

Richard Schmidt of Biloxi has been elected to the board of directors of First Federal Savings and Loan Association of Biloxi. Dr. Schmidt is a pediatrician.

The Field Clinic of Centreville announces the association of Shelby Smith, Tom Carey, and Bert Bradford of McComb for the treatment of diseases of children each Wednesday morning.

W. Lamar Weems of UMC participated in the Southern Medical Association's section secretaries conference in Atlanta.

Ray L. Wesson of Ocean Springs was recently inducted as a Fellow of the American College of Surgeons.

William B. Wilson of Jackson made a talk in Chicago before the Illinois Society of Pathologists on "Clinical Application of Radioimmunoassay."

Book Reviews

Symposium on Aesthetic Surgery of the Nose, Ears, and Chin. Vol. 6. Edited by Frank W. Masters, M.D., and John R. Lewis, Jr., M.D. 207 pages with 514 illustrations. St. Louis: The C. V. Mosby Co., 1973. $37.50.

This book is Volume Six of a series of symposia sponsored by the Educational Foundation of the American Society of Plastic and Reconstructive Surgery, and it is the second in the series concerning cosmetic surgery. Other symposia have been on subjects such as cancer of the head and neck, facial trauma and the hand.

While some of the symposia have been of interest to surgeons in general, this volume and its predecessor on cosmetic surgery should be of interest only to the plastic surgeon.

This book is divided into three parts. Part one is on rhinoplasty, while part two is on cosmetic surgery of the ears and part three is on cosmetic surgery of the chin and non-surgical considerations of the nose, ears and chin.

In each of the first two parts, there is a short history on the subject and in a book such as this, this is always interesting. Also, in these sections are to be found normal anatomy and physiology sections.

The Educational Foundation, as in all of its symposia, has chosen its contributors wisely. The men chosen are without exception leaders in the field of plastic surgery and specifically in cosmetic surgery.

Part one, which is on rhinoplasty, is exceptionally good. The techniques of the different steps in performing a rhinoplasty are described in great detail and in most cases with great clarity. Two of the presentations are outstanding: Dr. Ralph Millard's paper on 25 helpful hints in corrective rhinoplasty and Dr. Mar McGregor and Dr. Lars Vistnes' paper entitled "Unsatisfactory Cosmetic Rhinoplasty" are the type which there should be more of. These papers are more or less "confessions" of plastic surgeons who do many rhinoplasties and are the type papers which make a symposium such as this a success. Another paper which is most helpful is Dr. James Hendrix's paper on "Reconstruction of the Nose with Local Flaps."

With the many malignances of the skin that are seen in the southern United States, this paper could be of interest to the family physician or general surgeon so he might be more able to explain to a patient what is available.

Part two is mainly concerned with prominent ears and macrotia. Several techniques are presented on prominent ears and in each instance the author shows excellent results. Macrotia is another problem altogether and the paper which is presented by Dr. Frederick McCoy shows quite clearly that there are several techniques available for this condition.

The main criticism which could be made of the book is in the area of illustrations. Some are well done while others are not quite as clear as they should be.

This book may be of some interest to the family physician, pediatrician and internist who are sometimes the first to be consulted about cosmetic surgery. This does not mean that the book could be used as reference, but a great deal can be gained by casual examination of this book by someone who does not deal with cosmetic surgery on a day-to-day basis.

Robert T. Love, Jr., M.D.
Greenville, Miss.

Current Surgical Diagnosis and Treatment. By J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1,108 pages with illustrations. Los Altos, Cal.: Lange Medical Publications, 1973. $14.00.

Drs. Dunphy and Way, along with 60 other contributing authors have made an excellent attempt to discuss various surgical diagnoses and problems for both medical students and practicing surgeons. The majority of the authors are associated with either the University of California in San Francisco or with Stanford University in Palo Alto although there are other contributors.

The reader will find that this text of surgery is broken down into 52 chapters, each chapter dealing with one specific aspect of surgery. The authors have tied the chapters in together well and have used basically the same format in writing each chapter. I found that some chapters seem to go into more detail with regard to diagnosis while others perhaps spent a little more time with treatment of

specific problems. In general, however, each surgical entity is covered in detail in each chapter. I was very impressed to find that after each subsection of each chapter, there were footnotes for those who were interested in looking into problems further, although in some cases, I felt that the footnotes, or references, were not the best in that field. However the references were indeed up-to-date and in looking at these references, one was referred to additional areas where he could gain information.

This text did impress me in that most all the material has been obtained from articles that were written in 1971 or 1972 which is quite an accomplishment for a book that is published in 1973. Although the print is small, I feel that the practicing surgeon will be extremely pleased to find that most things were broken down in such a manner that he ean obtain the information easily without looking through several different areas.

Although surgical technique is not stressed in this book, I feel that the surgery resident and surgical student will find this book of benefit in the diagnosis of various problems as well as planning the treatment for those problems. It delves into both pre- and postoperative care.

In summary, I feel that this book would indeed serve as an excellent surgical text for one who is interested in the broad field of general surgery and is looking for a book to help him through the routine day-by-day surgical problems.

W. Briggs Hopson, Jr., M.D.
Vicksburg, Miss.

Medico-Legal Briefs

$675,000 VERDICT AGAINST DRUG MANUFACTURER

A patient who suffered irreversible side-effects after treatment with a combination of three drugs was awarded $675,000 by an Illinois jury.

From Aug. 24 to Oct. 9, 1965, the patient, a 62-year-old man, was hospitalized for the first time in his life because of an infected skin ulcer caused by venous stasis on the lower part of his right leg. A physician prescribed bed rest, hot wet packs, and antibiotics.

The physician finally performed a double operation to repair a right inguinal hernia and graft tissue from that area to the patient's leg. Both operative sites became cross-infected with Bacillus Proteus, and the graft failed.

After consultation, the patient was given a cumulative amount, in daily doses, of 7 gm. of streptomycin, 2.85 gm. of Coly-Mycin, and then 13 gm. of Kantrex (kanamycin). He became completely deaf with vestibular paralysis of the inner ear. He fell, fracturing his hip, which required pinning and later a full prosthesis. Gout developed with uric acid deposits in joints, which was also irreversible. Experts blamed the gout on kidney damage.

The patient brought action against the hospital, two physicians, and the manufacturer of Kantrex. He contended that in its 1965 package insert the drug company failed to pass on to physicians information from clinical research on adverse reactions after combining the three drugs.

In 1959 a physician recommended eight guidelines for using Kantrex but the company omitted some of them including the one against combining the drug with other drugs. The company also failed to check a warning from a university in 1961. In 1962, with FDA approval, the company removed a warning that toxicity might be greater in patients over 45.

The treating physician testified that he would not have given Kantrex to the patient if he had known what he later learned about it. It was argued that all physicians should have known not to mix antibiotics, but a 1965 letter from the company medical director admitted that they probably did not.

The court did not permit a punitive damage count to go to the jury. The patient was brought into the courtroom once in a wheelchair. He was permitted to walk to the stand with a walker and answer questions with no cross-examination. The court directed a not guilty verdict for all parties except the drug company.—Bochum V. Sherman Hospital (Ill.Cir. Ct., Kane Co., Docket No. 70L-10196, Sept. 28, 1973)



Arens, James F., Jackson. Born Hamel, Minn., April 20, 1934; M.D., Creighton University School of Medicine, Omaha, Neb., 1959; interned Tripler Army Hospital, Honolulu, Hawaii, one year; anes-

thesiology residency, Charity Hospital, New Orleans, La., 1960-1962; elected by Central Medical Society.

Brown, Hugh P., Jackson. Born Siseton, S. D., May 9, 1940; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1965; interned Wilford Hall USAF Hospital, Lackland AFB, San Antonio, Tex., one year; orthopaedic surgery residency, Tulane Medical School, New Orleans, La., 1969-1972; elected by Central Medical Society.

Burke, Pat S., Clarksdale. Born Greenville, Miss., Sept. 19, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Wilford Hall USAF Hospital, San Antonio, Tex., one year; internal medicine residency, same, 1969-72; elected by Clarksdale and Six Counties Medical Society.

Duggar, Perry N., Jackson. Born New Hope, Ala., May 9, 1936; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned Keesler AFB Hospital, Biloxi, Miss., one year; anesthesiology residency, Lackland AFB Hospital, San Antonio, Tex., 1967-69; elected by Central Medical Society.

Genre, Charles F., Jackson. Born New Orleans, La., Sept. 28, 1940; M.D., Tulane University School of Medicine, New Orleans, La., 1966; interned Confederate Memorial Medical Center, Shreveport, La., one year; pathology residency, Tulane Medical Center, New Orleans, La., 1967-1971; elected by Central Medical Society.

Gorton, Walter M., Belzoni. Born Lambert, Miss., April 2, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned Lloyd Noland Hospital, Fairfield, Ala., one year; internal medicine residency, University Medical Center, Jackson, Miss., 1970-73; elected by Delta Medical Society.

Lamar, Wayne T., Oxford. Born New Albany, Miss., Mar. 16, 1939; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned UMC, Jackson, Miss., one year; orthopaedic surgery residency, Kennedy VA Hospital, Memphis, Tenn., 1967-68; orthopaedic surgery residency, Campbell Clinic, Memphis, Tenn., 1968-71; elected by North Mississippi Medical Society.

Lamppin, Douglas W., Pascagoula. Born Louisville, Ky., April 6, 1937; M.D., Tulane University School of Medicine, 1963; interned Brooke General Hospital, Fort Sam Houston, Tex., one year; otolaryngology residency, Baylor Medical Center, Houston, Tex., 1968-72; elected by Singing River Medical Society.

Lee, John P., Forest. Born Philadelphia, Miss., Feb. 17, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned US Naval Hospital, San Diego, Calif., one year; surgery residency, UMC, Jackson, Miss., 1972-73; elected by Central Medical Society.

Medlin, James R., Ecru. Born Ripley, Miss., Sept. 20, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned St. Elizabeth Hospital, Covington, Ky., one year; elected by Northeast Mississippi Medical Society.

Odom, Cecil D., Jackson. Born Hattiesburg, Miss., Aug. 5, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned St. Elizabeth Medical Center, Dayton, Ohio, one year; ob-gyn residency, UMC, Jackson, Miss., 1970-73; elected by Central Medical Society.

Platt, Lucas O., Tupelo. Born Summerville, Ga., Mar. 7, 1938; M.D., University of Mississippi Medical School, Jackson, Miss., 1968; interned same, one year; urology residency, same, 1969-73; elected by Northeast Mississippi Medical Society.

Rankin, Gerald M., Vicksburg. Born Vicksburg, Miss., April 1, 1944; M.D., University of Tennessee College of Medicine, Memphis Tenn., 1969; interned USC Medical Center, Los Angeles, Calif., one year; ob-gyn residency, City of Memphis Hospitals, Memphis, Tenn., 1970-73; elected by West Mississippi Medical Society.

Spence, James E., Hattiesburg. Born Hattiesburg, Miss., Oct. 15, 1937; M.D., Tulane University School of Medicine, New Orleans, La., 1963; interned US Naval Hospital, Portsmouth, Va., one year; internal medicine residency, Ochsner Foundation Hospital, New Orleans, La., 1968-1971; elected by South Mississippi Medical Society.

Steward, Edward A., Batesville. Born Wyatte, Miss., Jan. 6, 1945; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned Methodist Hospital, Memphis, Tenn., one year; elected by North Mississippi Medical Society.

Woodruff, R. E., Aberdeen. Born Gadsden, Ala., Oct. 3, 1896; M.D., Meharry Medical College, Nashville, Tenn., 1927; elected by Northeast Mississippi Medical Society.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Mar. 4-8, 1974

CARDIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Mar. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
James R. Galyean, M.D., assistant professor of medieine, The University of Mississippi School of Medieine

The course will familiarize physicians with eurrent eoncepts in bedside diagnosis of heart diseasc. Practieal points in physieal diagnosis and in review of the various forms of heart disease will be covercd, using pulse tracings, phonoeardiograms, electrocardiograms, x-rays, and hemodynamic data. Partieipants will round, witness cardiac catheterizations and discuss surgery procedures.

Mar. 14-16, 1974

SURGERY CONFERENCE

Medical Center Holiday Inn, Jackson
Mar. 14-16, 1974

Sponsored by The University of Mississippi Medical Center Department of Surgery and the Continuing Education Committee

Coordinators:
James D. Hardy, M.D., professor and ehairman of the Department of Surgery, The University of Mississippi Sehool of Medicine
William O. Barnett, M.D., professor of surgery, The University of Mississippi School of Medieine

This eonferenee brings together an outstanding group of surgeons for a three-day discussion of the latest knowledge and techniques in surgieal emergeneies of the abdomen. Lectures will take up severe malabsorption syndromes, endoerine emergencies, perforations of the eolon, prevention of infeetions in surgieal patients and surgieal emergencies in the newborn. Guest speakers include Dr. William Altemeier, professor of surgery at the University of Cineinnati Medieal Center; Dr. Frank Glenn, professor of surgery emeritus at Cornell University Medieal Center; Dr. George Jordan, professor of surgery at Baylor College of Medicine; and Dr. Walter Ballinger, head of the Department of Surgery at Washington University Sehool of Medieine. Advanee registration and a fee of $150.00 are required.

Mar. 18-22, 1974

NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

University Medieal Center, Jaekson
Mar. 18-22, 1974

Sponsored by The University of Mississippi Sehool of Medieine, with support from Maternal and Child Health Services Children's Bureau

Coordinator:
Alfred W. Brann, Jr., M.D., assistant professor of pediatrics and director, newborn eenter, The University of Mississippi Sehool of Medieine

This eourse, presented in February and repeated in March, is planned for physician/nurse teams. Most of thc content will be presented in joint sessions, with ample time allowed for diseussion of special problems in hometown nurseries. It is open to physicians involved in the eare of newborns as the primary physician. There is a $10.00 fee for physieians.

April 8-12, 1974

PULMONARY MEDICINE INTENSIVE COURSE

University Medical Center, Jackson
April 8-12, 1974

Sponsored by The University of Mississippi Sehool of Medieine, with support from thc Mississippi Regional Medieal Program

Coordinators:
Joe R. Norman, M.D., professor of medieine, Christmas Seal Professor of Pulmonary Diseasc, and director of the Pulmonary Division, The University of Mississippi School of Medieine
A. W. Conerly, M.D., instruetor in medicinc and director of respiratory therapy, Thc University of Mississippi School of Medicine

An integrative approach to the more eommon pulmonary problems will be the focus of this eourse. Formal leetures will eover respiratory failure, asthma, ventilators, tubereulosis and fungal disease. Daily rounds will emphasize physieal diagnosis, pathophysiology and diagnostie teehniques. The annual Boswell Leeture will be presented on Friday.

April 22-26, 1974

RADIOLOGY INTENSIVE COURSE

University Medical Center, Jackson

April 22-26, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Robert D. Sloan, M.D., professor and chairman of the Department of Radiology, The University of Mississippi School of Medicine

The course will include practical observations of radiologic procedures in the diagnostic, therapeutic, and isotope areas and sessions on equipment, techniques, artefacts, and radiation safety. Participants will play an active role in numerous diagnostic conferences on radiographic interpretation.

All the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

FUTURE CALENDAR

Mar. 4-8, 1974
CARDIOLOGY INTENSIVE COURSE

Mar. 14-16
SURGERY CONFERENCE

Mar. 18-22
NEWBORN SHORT COURSE FOR DOCTORS AND NURSES

April 8-12
PULMONARY MEDICINE INTENSIVE COURSE

April 19
RENAL SEMINAR

April 22-26
RADIOLOGY INTENSIVE COURSE

May 6-9
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

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SBH Warns Against Royal Treat Mushrooms

The Mississippi State Board of Health has issued a warning against the purchasing of mushrooms produced and packed in Ecuador by the American Mushroom Co., Quito, Ecuador.

According to State Health Officer, Dr. Alton B. Cobb, "Royal Treat" brand of mushrooms—2 oz. and 4 oz. cans—are being recalled due to clostridium botulinum Type B Spores found in some canned samples. "This is indicative of under-processing," explained Dr. Cobb, "making the contents unfit for consumption."

Through the efforts of the Board of Health's Local Health Services Division, Mississippi's grocery stores and supermarkets have already been informed of the recall and in addition, "local sanitarians will be doing some spot checking throughout the state," noted Paul Rankin, Advisory Sanitarian.

The Health Department emphasizes the fact that "only those mushrooms produced and packed in Ecuador are included in the recall. All others are perfectly safe."

Former UMC Dean Accepts Florida Post

Dr. Robert Q. Marston, former vice-chancellor of the University of Mississippi at the Medical Center and dean of the School of Medicine, has been named president of the University of Florida.

Marston, who held the top post at the Medical Center from 1961 to 1966, was named to the presidency of Florida's largest university in mid-January.

He will succeed Stephen O'Connell, who retired last summer, as the University's seventh president.

Marston, 51, was director of the National Institute of Health from 1968 to 1973 and is currently a scholar in residence at the University of Virginia School of Medicine.

He is expected to assume his new duties this summer.

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

Feb. 25-Mar. 10

Treatment of Pulmonary Embolism, with William Hall, M.D., director of the Pulmonary Function Unit, Strong Memorial Hospital; Assistant Professor of Medicine, University of Rochester School of Medicine, Rochester, N. Y.

The Five-Minute Joint Exam, with John J. Calabro, M.D., Chief of Rheumatology, Worcester City Hospital; Professor of Medicine, University of Massachusettes Medical School.

Detecting Open Angle Glaucoma, with Jerome N. Goldman, Attending Ophthalmologist, Washington Hospital Center, Assistant Clinical Professor of Ophthalmology, Howard University Medical School, Washington, D. C.

Mar. 11-24

The Breast Examination, with Angelo J. DePalo, M.D., Assistant Attending Surgeon, Memorial Hospital for Cancer and Allied Diseases, New York City.

Is It Sinusitis?, with Melvin E. Sigel, M.D., Clinical Associate Professor of Otolaryngology, University of Minnesota Medical School, and Assistant Chief of the Department of Otolaryngology, Hennepin Co. General Hospital, Minneapolis, Minn.

An Effective Way to Control Psoriasis, with Paul Lazar, M.D., Associate Professor of Dermatology, Northwestern University; Chairman of the Audio-Visual Committee at the American Academy of Dermatology; and Chairman of the AMA Task Force on Cosmetics, Evanston, Ill.

Mar. 25-Apr. 7

Alopecia in Diagnosis, with Norman Orentreich, M.D. Clinical Associate Professor of Dermatology and Syphilology, New York University School of Medicine, New York City.

The Medical Management of Metastatic Breast Cancer, with Justin J. Stein, M.D., Professor of Radiology and President of the American Cancer Society, University of California, Los Angeles.

The Differential Diagnosis of Systemic Lupus Erythematosus, with Naomi F. Rothfield, M.D., Professor of Medicine and Chief, Arthritis Division at the University of Connecticut School of Medicine, Farmington.

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change)

The 106th Annual Session of MSMA at Biloxi Will Offer Something for Everyone

Outstanding guest speakers for the scientific meeting and numerous business and social occasions have been lined up for the 106th Annual Session of the Mississippi State Medical Association, May 6-9, 1974, at Biloxi.



Dr. Spell

Dr. James P. Spell of Jackson, chairman of the Council on Scientific Assembly, made the announcement and stated that the convention will again be held at the Sheraton-Biloxi Hotel.

The annual session opens with the House of Delegates on Monday morning, May 6. Dr. Russell Roth, AMA president, will be special guest speaker. The House also meets on Thursday afternoon when MSMA policy will be decided and officers elected.

The Scientific Assembly opens on Tuesday, May 7. Seven scientific section meetings will offer presentations in surgery, medicine, preventive medicine, family practice, ob-gyn, pediatrics and EENT. Guest essayists number 18 and include Drs. Floyd Denny, chairman of pediatrics at the University of North Carolina; Edward M. Sankary of Fort Worth; Stewart L. Nunn of Memphis VA Hospital; Stanley B. Garbus of New Orleans; Marcel Patterson, Department of Medicine, University of Texas Medical Branch at Galveston; Winfred L. Wiser, professor of ob-gyn at the University of Tennessee; Julius N. Hicks of the University of Alabama at Birmingham; and John L. Sawyers, professor of surgery at Vanderbilt.

Thirteen specialty groups will have concurrent meetings, and medical alumni from Ole Miss, Tennessee, Tulane and Vanderbilt are scheduling social occasions. The annual association fellowship party is on the Wednesday evening agenda.

New this year will be a membership-wide fellowship breakfast scheduled for Tuesday morning at the Top of the Sheraton.

Some 20 scientific exhibits will be offered to convention-goers as well as over 30 technical exhibits by ethical pharmaceutical manufacturers, medical supply houses, etc.

The Woman's Auxiliary is finalizing plans for its concurrent annual session and the presidents of the AMA Woman's Auxiliary and the Southern Medical Association Auxiliary will be special guests.

Other events slated for convention week include the Fifty Year Club, Past President's Breakfast and various related group meetings.

Early registration at the Sheraton-Biloxi is recommended and convention officials are predicting a sellout by April. The MSMA headquarters office is handling hotel reservations and advance registration forms are being sent to all MSMA members.

The entire annual session program and the House of Delegates handbook will be printed in the April issue of the JOURNAL MSMA.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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110,000 State Residents Get Supplemental Income

In the first week of January, 110,000 Mississippi residents received their first payments under the new Supplemental Security Income program, according to John F. Pate, manager of the Jackson social security office.

The payments were made to two groups of individuals. The first group were those who received state payments in December 1973, because they were age 65 or older, or blind or disabled and were automatically changed over to the new federal program. The other group were those who could not qualify under the state program, but filed during the last of 1973 with social security and qualified under the new federal standards.

Mr. Pate states, "I am sure many additional Mississippians could have received the initial payment; however, due to their lack of awareness of the program they did not file a timely claim. It should be emphasized that no payments can be made retroactively, so eligible individuals should file immediately to prevent any further loss of benefits."

The Supplemental Security Income payments are generally payable to individuals who have a monthly income of less than $160 or couples who have a monthly income of less than $230. Individuals considered for payment must be age sixty-five or older, blind or disabled. The payments and applications for payment are being handled by the Social Security Administration. Financing, however, is through the U. S. Treasury—not social security trust funds. The new program was enacted into law in order to provide a nationwide income floor for the aged and disabled whose income and resources are below designated levels.

Mr. Pate stated, "The Supplemental Income payments are made in varying amounts, but under current law, the maximum payment will not exceed $140 for an individual or $210 for a married couple." He urged persons desiring more information concerning the program to visit their local social security office.

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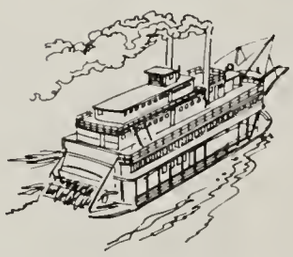

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AMA Appoints New Congressional Director

Dr. John Zapp, D.D.S., Deputy Assistant Secretary for Legislation of the HEW Department, is resigning to join the Washington office of the AMA as director of the Department of Congressional Relations.

Dr. Zapp has been at HEW since 1969. He held a variety of posts including deputy assistant secretary for health manpower. The 41-year-old official has been involved with health legislation for several years and has served as federal representative to the AMA-American Medical Colleges Liaison Committee on Medical Education.

Dr. Zapp will replace William Colley as the head of AMA's Congressional Relations Department.

EEG Society Calls for Papers

The American Electroencephalographic Society's 28th Annual Meeting will be held July 25-27, 1974, at the Seattle Center, Seattle, Washington.

The Program Chairman, Dr. G. E. Chatrian, hereby issues a *call for papers* to be presented at the Scientific Sessions. The meeting will be preceded by a three-day Course in Clinical Electroencephalography. The American Society of Electroencephalographic Technologists will meet at the Seattle Center on July 26 and 27 and will conduct courses in both Basic and Advanced Electroencephalographic Technology on July 24 and 25.

Instructions for presentation of abstracts, applications for courses and further information on both meetings may be obtained from the Executive Secretary, Mrs. Margaret H. Henry, The American EEG Society, 4137 Erie Street, Willoughby, Ohio 44094.

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SBH Licensing Examinations Explained

Examinations for medical licensure are given in June and December of each year in Mississippi, with the State Board of Health designated by law as the licensing agency for physicians, osteopaths and podiatrists.

In June 1973, Mississippi joined 47 other states in adopting a new testing method for medical graduates—the Federation Licensing Examination (FLEX).

The purpose of this exam is to provide state medical boards with a high quality, uniform, and valid examination.

Scheduled for a 3-day period, the first day consists of a comprehensive examination of the basic sciences; the second day the clinical sciences are covered, and the third day is devoted to an objective test of clinical competence similar to that of the National Boards, Part III.

Test questions are selected by the Federation of State Medical Boards' Examination Committee. There are 27 members on this committee, plus the chairman, with all chosen from the states participating in the FLEX Program.

Dr. W. Moncure Dabney of Crystal Springs, a member of the State Board of Health, is presently serving on this committee.

Of the 127 physicians taking the FLEX in Mississippi last June, 101 passed and 26 failed. Among the 26 who failed were 13 graduates of foreign schools of medicine. Eighty-seven medical graduates from the University of Mississippi were tested with a failure rate of only 11.5 per cent.

Also taking the exam were 24 medical graduates from schools of medicine in other sections of the country.

A score below a FLEX-weighted average of 75 is termed failing; the overall failure rate of this FLEX group was 20.5 per cent or 26 out of the 127 students failing. Statistics from all the states giving FLEX are not yet available for this exam.

"We are pleased with the FLEX testing procedure," stated Dr. Frank J. Morgan, Jr., Assistant State Health Officer for Licensure and Certification at the Board of Health.

"The test is quite thorough," he noted. "We feel that the use of FLEX nationwide will help solve some of the problems in medical licensure, especially in reciprocity with other states."

The next FLEX will be given on June 11, 12, and 13, 1974, in 48 states, Jackson being the testing site in Mississippi.

UMC Advises Students on Medical Careers

High school students interested in medical careers are getting help in planning their futures in a pilot program on Saturday mornings at the University Medical Center in Jackson.

The first medical science institute for high school students was held Jan. 19. UMC Vice Chancellor Dr. Norman Nelson and Associate Dean Dr. Carl Evers explored the variety of career opportunities and programs offered at the Medical Center complex.

Peter Stewart, coordinator of minority student affairs, says that on subsequent Saturdays UMC faculty will cover practically every facet of medicine —research, surgery, orthopedics, electrocardiography, family and infant medicine, anesthesiology, obstetrics and gynecology, radiology, pathology, health related fields, and specialized medicine.



Peter Stewart, center, coordinator for the Saturday Institute of Medical Science, reviews plans for the sessions with UMC Vice Chancellor Dr. Norman Nelson, left, and Associate Dean Dr. Carl Evers, right. Along with 18 other UMC faculty members, they are helping high school students learn about and plan careers in medicine.

$2 Million Granted for Chiropractic Study

Congress has granted the National Institute of Neurological Diseases and Stroke (NINDS) a $2 million appropriation for an "independent, unbiased study of the chiropractic profession."

In adding its approval to a House appropriation bill for the Department of HEW, the Senate Committee on Appropriations directed funding for the chiropractic study in these words:

"In view of the recent inclusion of chiropractic services under Medicare, this would be an opportune time for an 'independent, unbiased' study of the fundamentals of the chiropractic profession . . . "

President Nixon later signed the bill into law.

Family Practice Announces Board Exam

The American Board of Family Practice announces that it will give its next two-day written certification examination on Oct. 19-20, 1974. It will be held in five centers geographically distributed throughout the United States.

Information regarding the examination may be obtained by writing: Dr. Nicholas J. Pisacano, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *June 15, 1974.*

Safer Rabies Treatment Reported in JAMA

A new rabies serum without side effects has been developed by researchers at the Center for Disease Control, the federal government research unit at Atlanta.

The new serum is extracted from human blood, from individuals who have previously been immunized against rabies. Until now, rabies serum has been extracted from the blood of horses. The horse blood serum is effective, but it produces unpleasant and potentially dangerous side effects in at least half of those receiving the injections.

In a report in the Jan. 28 issue of the *Journal of the American Medical Association,* the research team recommends that, on the basis of their findings, Human Rabies Immune Globulin (HRIG) be given to those individuals bitten by rabid dogs and other animals.

The serum is given in conjunction with the standard rabies vaccine, to speed the body's immune defenses against the disease.

"HRIG appears to be both safer and at least as potent as equine antirabies serum, and it should be substituted for the equine product," the report says.

The report is by Michael A. W. Hattwick, M.D., Robert H. Rubin, M.D., Stanley Music, M.D., R. Keith Sikes, D.V.M., Jean S. Smith and Michael B. Gregg, M.D.

MSMA Meets With Sheraton Staff



Representatives of MSMA met at Biloxi recently with the new management of the Sheraton-Biloxi Hotel to discuss arrangements for the 106th Annual Session of the association to be held May 6-9. From left are Mr. Tom Russell, new general manager of the Sheraton, Barbara Shelton, MSMA membership director who handles convention registration, and Dr. James P. Spell, Secretary-Treasurer of the association and Chairman of the MSMA Council on Scientific Assembly. Also present at the meeting were H. Cody Harrell, Assistant Executive Secretary, Nola Gibson, Council Secretary, and various department heads of the hotel.

ACOG Plans Annual Meeting

The 22nd Annual Clinical Meeting of The American College of Obstetricians and Gynecologists will be held April 29-May 2, 1974, in Las Vegas.

Highlights will include papers on current clinical and basic investigation; the President's Program, "The Conquest of Breast Cancer"; the management of breast cancer (diagnosis, treatment, rehabilitation); current concepts, etiology, pathology and research.

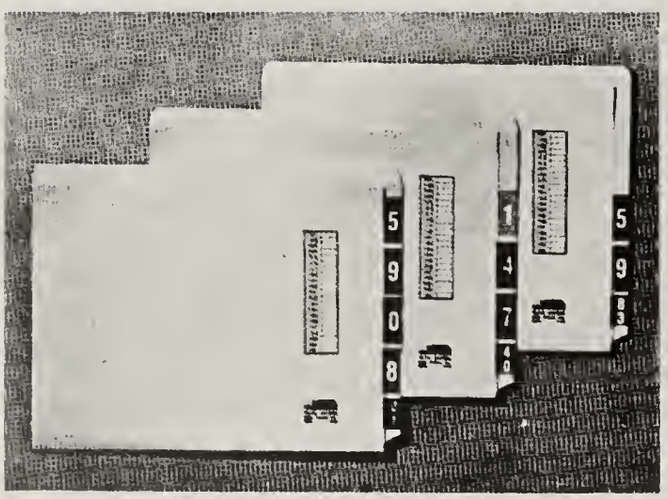
There will be 15 position papers with current thinking on the more common and important problems in the specialty as seen by prominent authorities. New films, special interest meetings (in six subspecialty areas), luncheon conferences, round tables, and PG courses comprise the rest of the program.

Registration fee for non-members is $125.00.

For more information, contact Mr. Donald F. Richardson, Associate Director, The American College of Obstetricians and Gynecologists, One East Wacker Drive, Chicago, Ill. 60601.

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Oxford Professor Speaks at UMC



Sir George Pickering, second left, professor of medicine at England's Oxford University, talks with three University Medical Center students during his visit there last month. The students are Bill Cushman of Jackson, left; Richard Waller of Marks, second right; and Dick Smith of Jackson, right.

Sir George spoke to UMC faculty and students about the subject of his soon-to-be-published book—the accomplishments and creativity brought about by illness.

According to his theory, "If people like Charles Darwin, Mary Baker Eddy, Florence Nightingale, Sigmund Freud and Marcel Proust hadn't been sick, they never would have accomplished the work which made them famous."

What all five of his famous characters had was DaCosta's syndrome, he said. But in each case, the psychoneurosis (or as he called it—"creative malady") caused distinctly different results.

AAP Offers Immunization Flyer

A one-page flyer urging parents to make sure their children are adequately immunized against communicable disease has recently been made available by the American Academy of Pediatrics.

The flyer warns that "One in three preschoolers aren't immunized" and points out that the childhood diseases like measles, rubella, polio, whooping cough, and diphtheria can cripple and kill children.

The flyer also contains an immunization schedule recommended by the academy, and urges parents to check with their family physician or local public health department if they are unsure about their child's immunization status.

The flyers are available from the American Academy of Pediatrics, Dept. P., Box 1034, Evanston, Ill. 60204. Price is $3 per 100 copies.

Even Chicago Stadium couldn't hold all the physicians the AMA helped put through school.



Every year, thousands of young men and women struggle to scrape up the funds to pay for their medical education and training. Many, though highly qualified, simply can't swing it alone.

Where can they turn for financial assistance? One important source is the American Medical Association Education and Research Foundation (ERF). It was set up in 1962 to help just such qualified individuals complete their training.

Through its Loan Guarantee Program, AMA-ERF has arranged for over $57 million in loans to more than 26,000 medical students, interns and residents in the last 11 years.

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Seminar on Care of Injured Set

Approximately 150 doctors are expected to attend a three-day seminar on "Life-Saving Measures for the Critically Injured," sponsored by the American College of Surgeons' Committee on Trauma and the department of surgery, University of South Florida, Tampa, Mar. 27-30, 1974.

The seminar is designed particularly for rural and general practitioners, physicians called upon most frequently to render primary medical care to the injured. Though aimed at the non-specialist and emergency department physician, the broad curriculum is also useful to surgical specialists and internists. This three-day course at the Holiday Inn Downtown, is one of 16 being held throughout the U. S. during 1973-74, by the Trauma Committee in cooperation with departments of surgery.

Dr. Roger T. Sherman, chairman of the department of surgery, Tampa General Hospital, and professor of surgery, University of South Florida College of Medicine, is course director. Dr. Sherman is also a member of the ACS Committee on Trauma.

A faculty of 17 experts in the field of trauma, serving as "teachers," will report on the latest in care of the injured. Four out-of-town speakers included in the faculty are Drs. Curtis P. Artz, professor and chairman of the department of surgery, Medical College of South Carolina, Charleston; Francis C. Nance, associate professor of surgery, Louisiana State School of Medicine, New Orleans; James W. Pate, professor and chairman of the Section of Thoracic and Cardiovascular Surgery, University of Tennessee College of Medicine, Memphis, and James L. Talbert, professor of surgery and pediatrics and chief of the Division of Pediatric Surgery, University of Florida College of Medicine, Gainesville. Also participating in the program is Edward L. Rood, LL.B., attorney at law, Tampa.

Topics to be covered during the seminar include: assessment of the critically injured patient; pathophysiology of shock—clinical correlations; care of the multiple injury patient in the emergency department; pulmonary physiology for the emergency department physician; maxillofacial and laryngeal injuries; thoracic, abdominal, and spinal cord injuries; genito-urinary tract injuries; current concepts of burn management, and many other topics of interest to physicians involved in care of the injured.

Dr. Oscar P. Hampton, Jr., director of the Trauma Division of the ACS, provides staff support for all trauma programs of the college. Financial support for this series of seminars is being provided under contract number NO1-PE-24393, Public Health Service, HEW.

The seminar is approved by the American Medical Association for credit toward Physician's Recognition Award, by the American College of Emergency Physicians for continuing education credit for members, and by the American Academy of Family Physicians for 21 credit hours.

Ob-Gyn Seminar Planned in Kentucky

The University of Kentucky Medical Center will host a seminar on current concepts in obstetrics and gynecology Mar. 14-16 in Lexington.

There will be a registration fee of $125 for the course.

For further information contact Dr. Ronald D. Hamilton, Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

Symphony Has Medical Connections



Heading the Jackson Symphony Orchestra's membership drive for 1974-75 are from left, Mrs. Harlon Varnado, Mrs. George Bell, Jr. (seated), and Mrs. J. Manning Hudson. They are shown with conductor Lewis Dalvit. Mrs. Hudson is the wife of a Jackson cardiologist and Mrs. Varnado is Executive Secretary of Central Medical Society. Theme of next year's concert series is "The Wide, Wide World of Music." (Photo courtesy of Northside Sun)

Chest Physicians Call for Abstracts

A "Call for Abstracts" has been announced by the American College of Chest Physicians. Physicians and surgeons are invited to submit abstracts of papers relating to the disciplines of circulation, respiration and thoracic-cardiovascular surgery. Accepted abstracts will form the basis for presentations at the 40th Annual Scientific Assembly to be conducted by the college in New Orleans, Nov. 3-7, 1974.

In addition, accepted abstracts (200 words maximum) will be published in *Chest,* the official publication of the American College of Chest Physicians. Membership in the college is not a prerequisite to participation in the program.

Presentations at the Scientific Assembly will be limited to 10 minutes, with an additional two minutes for discussion.

The deadline for submitting abstracts to the college is *April 30, 1974.* All applicants will be notified of the decision made by the Scientific Program Committee within six weeks after the deadline.

Submission of abstracts, as well as inquiries on details of requirements, should be directed to: Dr. John T. Sharp, Chairman, Scientific Program Committee, American College of Chest Physicians, 112 E. Chestnut Street, Chicago, Ill. 60611.

Symposia Medica Plans Cardiovascular Meet

Symposia Medica Foundation will present an international conference on Clinical Aspects of Cardiovascular Disease in London, England, May 17-25, 1974.

For further information, contact: Ms. Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York, N. Y. 10010.

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Internists Hold Annual Meeting

The 55th Annual Session of the American College of Physicians (ACP) will be held in New York City April 1-4, 1974, with scientific sessions at the New York Hilton and Americana hotels.

The college, an international organization of some 26,000 specialists in internal medicine and related fields, expects 6,000 physicians to attend the four days of scientific lectures, panel discussions and other events aimed at helping clinicians keep informed of new knowledge and developments in the basic and clinical sciences that affect their diagnosis and treatment of diseases.

Theme of the 1974 Annual Session will be "Humoral and Chemical Mediators in Human Biological Systems." Special lectures, panel discussions and informal, unstructured "Meet the Professor" sessions will be held throughout the week, with emphasis on the theme subject.

Out of 480 abstracts of scientific papers submitted for consideration by the Annual Session Program Committee, 78 have been selected for presentation. They will be grouped under the topic headings of allergy and immunology; endocrinology and metabolism; gastroenterology; heart; circulation; hematology; infectious diseases; kidney, electrolytes and hypertension; neurology; oncology; psychiatry; pulmonary diseases; rheumatology; nutrition and delivery of health care.

Twelve distinguished medical scientists are scheduled to present State of the Art lectures and six programs will be telecast via closed circuit from Cornell Medical College to the Americana hotel. (Two programs will be shown twice.)

The College's Annual Convocation, at which new Fellows will be inducted and special awards given, will be held on Monday, April 1. Dr. Walter B. Frommeyer, Jr., Birmingham, Ala., ACP president, will address the convocation audience.

AMA Sponsors Rural Health Conference

"Rural Health Is a Community Affair" will be the theme of the 27th National Conference on Rural Health of the American Medical Association, April 25-26, 1974, at Detroit Hilton Hotel.

Conference goals will be four-fold, said Bond L. Bible, Ph.D., director of the AMA's Department of Rural Health:

* To assess the use of all resources in planning for and implementing health care delivery systems.
* To examine the recruitment, education and utilization of rural health manpower.
* To understand the function and development of a rural emergency medical service system.
* To study a strategy for making rural health care services available and accessible.

Dr. Malcolm C. Todd, president-elect of the AMA, of Long Beach, Calif., will open the conference with the keynote address on "A National Strategy for Rural Health."

A symposium on "Directions for the Future" will include Dr. B. Lewis Barnett, Jr., of Medical University of South Carolina, Charleston; Lucy H. Conant, R.N., Ph.D., dean of the School of Nursing of the University of North Carolina, Chapel Hill, and Dr. Loman C. Trover, president of the American Association of Medical Clinics, of Madisonville, Ky., with Dr. Julian C. Lentz, Jr., vice chairman of the AMA's Council on Rural Health, of Prescott, Ariz., as moderator.

A major portion of the conference will be devoted to workshops, on such topics as "The Rural Medical Center—Directions for the Future," "Problems and Prospects for Rural Emergency Care," "Allied Health Professionals—Extending the Services of the Rural Physician," "Rural Health Care Studies—Their Implications," "Physician Recruitment and Related Factors," "Winds of Change—Some Developments for Rural Health Services," and "Health Teams in Rural Practice."

Further information on the conference is available from the Department of Rural Health, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

AAP Spring Session Set for Bal Harbour

More than 2,000 child health professionals from throughout the hemisphere are expected to attend the American Academy of Pediatrics' annual Spring Session at the Americana Hotel in Bal Harbour, Fla., April 22-25, 1974.

The scientific sessions, open to all registrants, will feature discussion on a variety of topics, including learning disabilities, trauma, care of the burned

child, advances in immunization, and the effects of televised violence on children.

A special plenary session will be devoted to the adolescent, with discussions of the ethics and mores of the adolescent, the truth about food and vitamins, and how to communicate with adolescent patients.

In addition, round table discussions will include problems of office management, and management of pediatric emergencies. Other round tables will discuss pediatric nephrology, neurology, hematology, dermatology, ophthalmology, and neonatology.

1973 Health Care Expenditures Listed

Health outlays last fiscal year for the nation reached $94.1 billion, an 11 per cent increase, the lowest rate in several years. The proportion of total health spending to the Gross National Product remained at the 1972 level—7.7 per cent. Per capita expenditures rose $41 to $441 including private and government spending.

The Social Security Administration's preliminary figures for the fiscal year that ended last July showed per capita private spending on health of $265 and government spending of $176 per person for the year.

The ratio of public versus private health spending continued the trend of two decades toward more government spending. The ratio for fiscal 1973 was 60.1 per cent private and 39.9 per cent public. In 1928 the corresponding ratio was 86.7 per cent and 13.3 per cent.

Of the $94 billion total, $36 billion went for hospital care, $18 billion for physicians' services compared with $32.6 billion and $16.6 billion the previous year.

Federal spending was estimated at $24.6 billion, up almost $2 billion; state and local, $12.9 billion, up more than $1.5 billion.

Expenses for prepayment and administration, largely private health insurance expenses, rose from $2.4 billion in fiscal 1972 to $3.3 billion in fiscal 1973.

Non-Narcotic Drug Abuse Studied

A symposium on the treatment of non-narcotic multiple drug abuse will be presented in Houston, May 20-23. Emphasizing clinical services for the poly-drug abuser, the symposium is designed for health care delivery professionals and paraprofessionals.

The first three days, May 20-22, emphasize the drugs that are abused, the patients who abuse them, and the treatment techniques in current use. The fourth day, May 23, provides workshops for small groups in diagnostic and treatment techniques and pharmacology of tolerance and addiction.

The program is coordinated by the staff of the Institute of Clinical Toxicology in Houston. A manual provided for participants will detail operational protocol.

Contributed papers are invited on the subject areas emphasized in the symposium or on other closely related subjects with a clinical orientation. Abstracts of papers for consideration should be received no later than March 20 and addressed to Program Coordinator, Institute of Clinical Toxicology, P.O. Box 2565, Houston, Tex. 77001.

Fee for the symposium is $100 and fee for each of the three workshops (psychodrama, diagnosis and treatment, or pharmacology) is $50.00.



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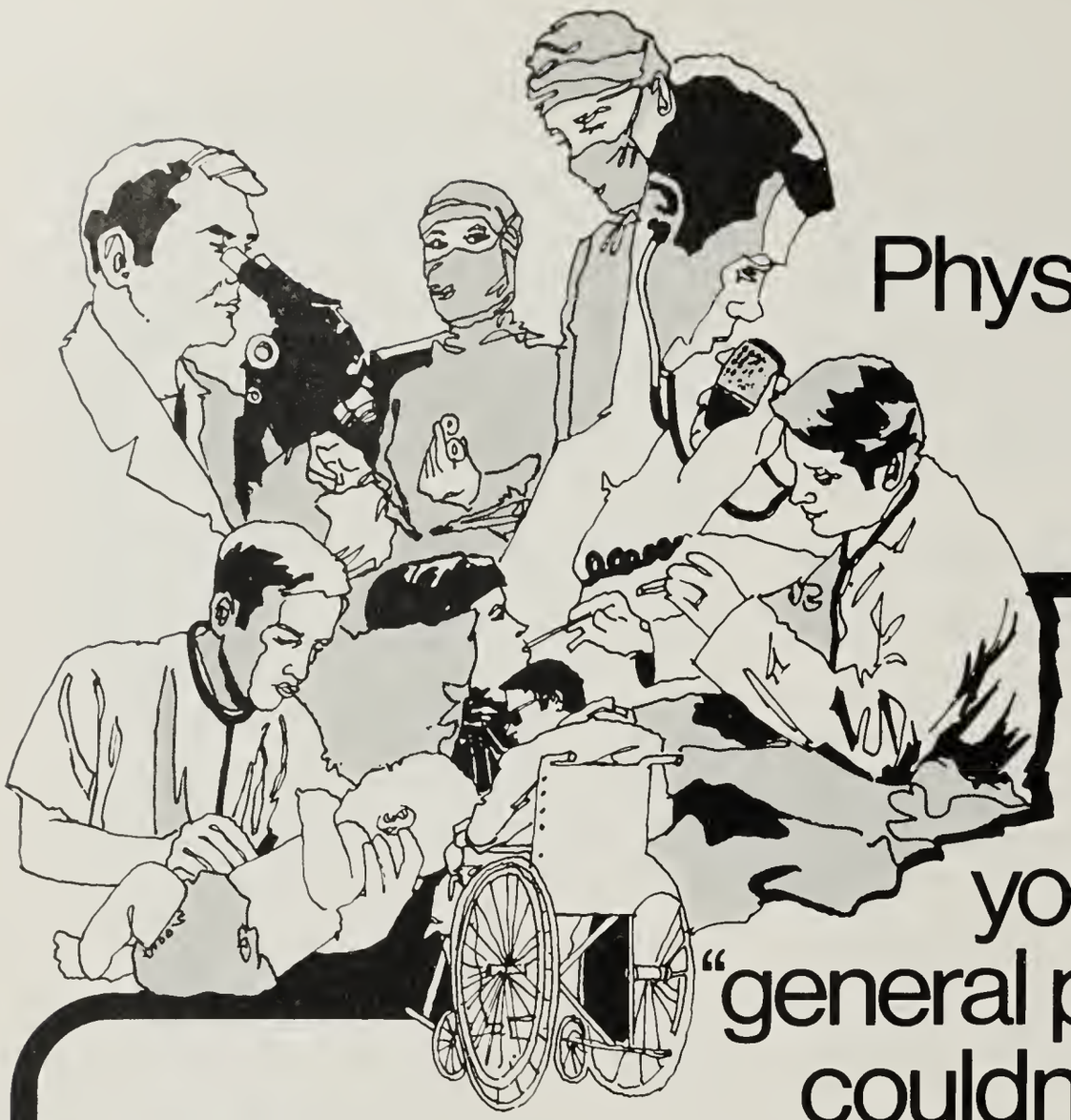
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IN CONCLUSION

U.S. Court of Claims has overruled report of Commissioner James F. Davis and dismissed the suit of Williams and Wilkins Company against National Institutes of Health and National Library of Medicine. Suit claimed that any copying of Williams and Wilkins' publications was an infringement of copyright. Court, by dismissing suit, in effect, upheld "fair use" concept that single copies of scientific articles could be provided to requesters without infringing copyrights.

Aetna Life and Casualty has produced a new illustrated booklet which is available free of charge for use in waiting rooms of the health professionals. Booklet is called "When Should You See A Doctor?" and stresses importance of routine health checkups and advises patients to seek advice during periodic checkups as to good health habits. Copies are available from Editorial Services, D-A, Aetna Life and Casualty, 151 Farmington Ave., Hartford, Conn. 06115.

HEW Secretary Caspar Weinberger has named PSRO Acting Director Dr. Henry Simmons officially as the permanent director of PSRO. Dr. Simmons will also remain the Deputy Assistant Secretary for Health. He was previously director of the Bureau of Drugs in the Food and Drug Administration. Dr. Simmons came to the federal government from the consulting firm of Booz, Allen and Hamilton, which has contributed several top HEW officials.

Changing from cigarettes to cigars may not be helpful in improving health, according to a recent investigation by Drs. J. Cowie, R.W. Sillet and K.P. Ball of London. Since most former cigarette smokers continue to inhale, their carboxyhemoglobin levels remain as dangerously high as before. To absorb nicotine a cigar smoker need not inhale, since alkaline cigar smoke -- unlike acid cigarette smoke -- can be absorbed through the mucous membranes in the mouth.

Football players' helmets and face masks cause broken noses, teeth and jaws, three medical specialists warn. Injuries are result both of inadequate face mask protection and helmets which do not fit properly, say Dr. Kent Wilson of the University of Minnesota Hospitals, Minneapolis, and Drs. Eugene and Michael Rontal of Detroit in a recent issue of Ophthalmology and Otolaryngology Transactions. The full-cage face mask provides the greatest amount of protection currently available.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

APRIL 1974

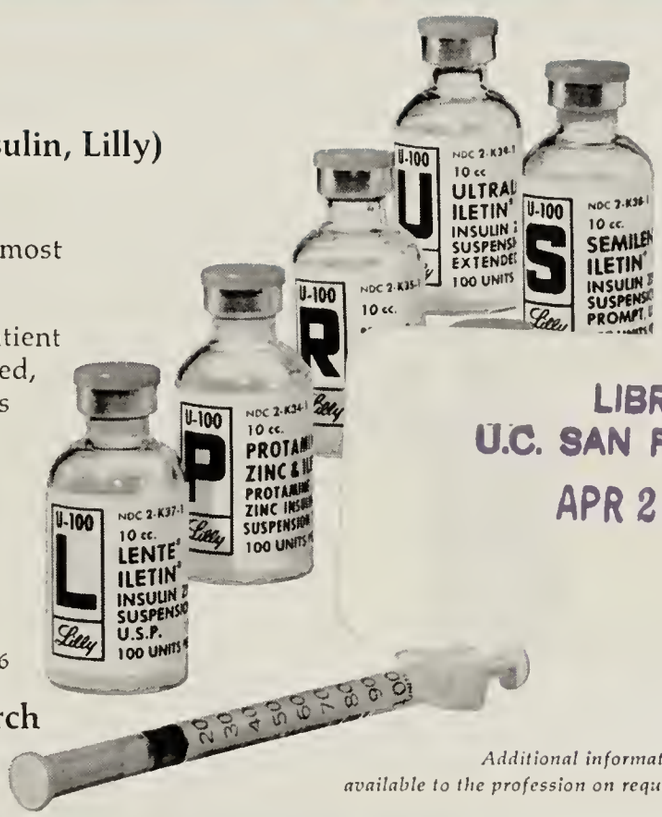
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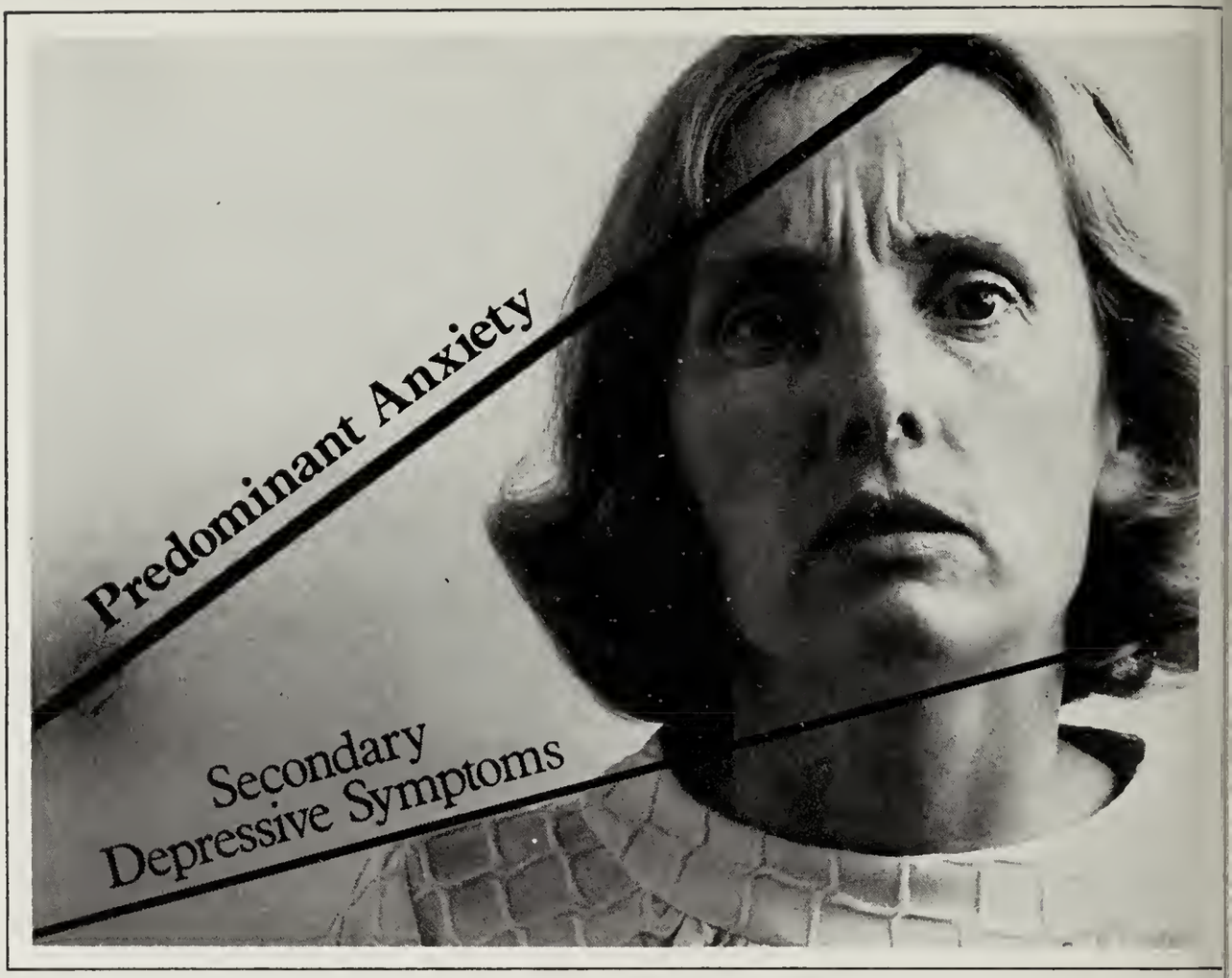
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Additional information available to the profession on request.

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This Month . . . Stress Ulceration,
Battered Child, Maternal Mortality
MSMA 106th Annual Session Program

M.S.M.A



This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Volume XV
Number 4
April 1974



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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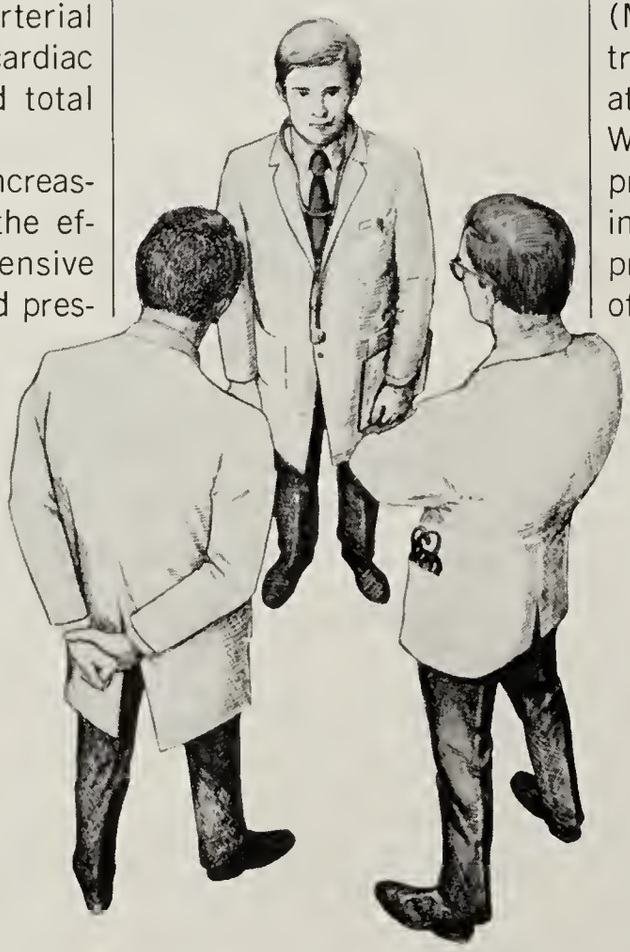
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The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



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With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

NEWSLETTER

April 1974

Dear Doctor:

The State Board of Health "having considered all evidence and other presentations made by all parties, having read, considered and discussed the arguments and the evidence, and in consideration of statutory provisions therefor," voted unanimously to place Talwin for parenteral use in Schedule II of the Mississippi Controlled Substance Act and to place Talwin for oral use in Schedule III thereof.

> This order will take effect on May 1, 1974, as ordered on March 8, 1974, by the Mississippi State Board of Health in regularly called session, according to Frank J. Morgan, Jr., M.D., Assistant State Health Officer for Licensure and Certification.

Nineteen of 22 specialty boards have formally approved voluntary periodic recertification exams, according to American Board of Medical Specialties. Board of Neurological Surgery opposes concept and Boards of Allergy and Immunology and Nuclear Medicine have not taken official stand; Family Practice will make periodic recertification mandatory.

Southern Medical Association area physicians may now use Dial Access System for toll-free telephone calls for the most recent diagnostic and therapeutic information on specific neoplastic disease problems. M.D. should dial 1-800-231-6970, state identity, and request specific number of any topic listed in SMA Cancer Education Service catalogue.

A letter to the New England Journal of Medicine editor points out hazards in dental offices to pacemaker wearers. When two peices of dental electrical equipment are used simultaneously, patient may be introduced into a power-line ground circuit. Current leakage could also interfere. M.D.'s should advise pacemaker patients to warn dentists.

A special television presentation, "I Am Joe's Spine," will be broadcast on Memphis WREC and New Orleans WWL on April 8. The half-hour show, produced with technical assistance of the American Academy of Orthopaedic Surgeons, is based on a Reader's Digest article. Physicians should anticipate calls for more information from patients.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

DATELINE

Hepatitis from Ear Piercing

Jackson, Miss. - Recent reports in the press and medical literature have revealed evidence that piercing ears under unsanitary conditions may result in transmission of hepatitis or other infectious diseases, according to State Health Officer, Dr. Alton B. Cobb. He urges physicians to inform patients that this procedure should be performed only under strict aseptic techniques.

New York Requires AMA Membership

New York, N.Y. - In a 153-44 decision, the House of Delegates of the Medical Society of the State of New York voted to amend its bylaws to require any physician applying for local or state membership also to join the AMA. Amendment becomes effective Jan. 1, 1975. MSSNY dropped mandatory AMA membership in 1970, when legal counsel said it violated state antitrust laws. Counsel now says 1970 opinion was incorrect.

Kennedy to Offer Drug Legislation

Washington, D.C. - Having concluded hearings on the advertising, marketing and promotional activities of pharmaceutical industry, Sen. Edward Kennedy said he will introduce legislation aimed at correcting some of the problems uncovered. "What we have now is a system of hard sell, rather than a system of objective information dissemination." He invited participation of industry.

Environmental Booklet Available

Washington, D.C. - The U.S. Environmental Protection Agency has available a new publication entitled "Health Effects of Environmental Pollution" which describes the health effects resulting from pollution in the environment. The 24-page color booklet gives insight on role of the environment in "causing" diseases like bronchitis and is available free from Office of Public Affairs, Dept. MED, Washington, D.C. 20460.

JCAH Has Heart, Cancer Studies

Chicago, Ill. - Joint Commission on Accreditation of Hospitals has released two year-long studies which index hospital-based capabilities to provide various levels of care for patients with heart disease or cancer. Dr. John D. Porterfield, JCAH director, said, "It is extremely important that medical professionals who perform in these areas take this opportunity to review and comment on these studies before adoption."

Now It's Flu Monday, Researchers Find

Blue Monday also might be dubbed "Flu Monday." The more edueation you have the more eolds you have. And the less money you have the more eolds you have.

Those findings appear in a study of "Aeute Respiratory Illness in an Ameriean Community," reported in the Jan. 14 issue of the *Journal of the American Medical Association.* The researeh, by Arnold S. Monto, M.D., and Betty M. Ullman, Ph.D., eovered 14,600 eases of respiratory illness in 4,905 residents of Teeumseh, Mieh., over a six-year period. The investigators, from the Sehool of Public Health at the University of Miehigan, got weekly illness reports by telephone from the families studied.

Some findings:

—The annual rate of illness deereased with inereasing age, exeept during the years 20-29, when it inereased, then resumed a deeline. The highest mean rate of illnesses was 6.1 illnesses per year, among infants under 1 year of age.

—At less than 1 year and at 1 to 2 years, boys had more siekness than girls, but at 3 the sex ratio reversed and girls got siek more often than boys. This pattern eontinued through all further age groups.

—More illnesses started on Monday than any other day, partieularly among the 5 to 19-year-olds, whieh happens to be sehool age. However, the doetors pointed out that this eould relate to the involvement of sehool in transmission of infeetion. Sueh transmission would oeeur mainly during the first days of the sehool week, and infeetions would develop into elinieal disease by the next weekend.

—Annual frequeney of respiratory illness deereased as ineome inereased, whieh is not unexpeeted as "lower ineome implied erowding and an inereased ehanee of transmission of infeetious agents," the investigators said.

—As edueational level inereased, respiratory infeetion rates rose. "This . . . may be related to the reeognized differenees in ability of individuals of varied baekgrounds to reeognize minor symptoms and to eonsider that they signify the existenee of disease," Drs. Monto and Ullman said.

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

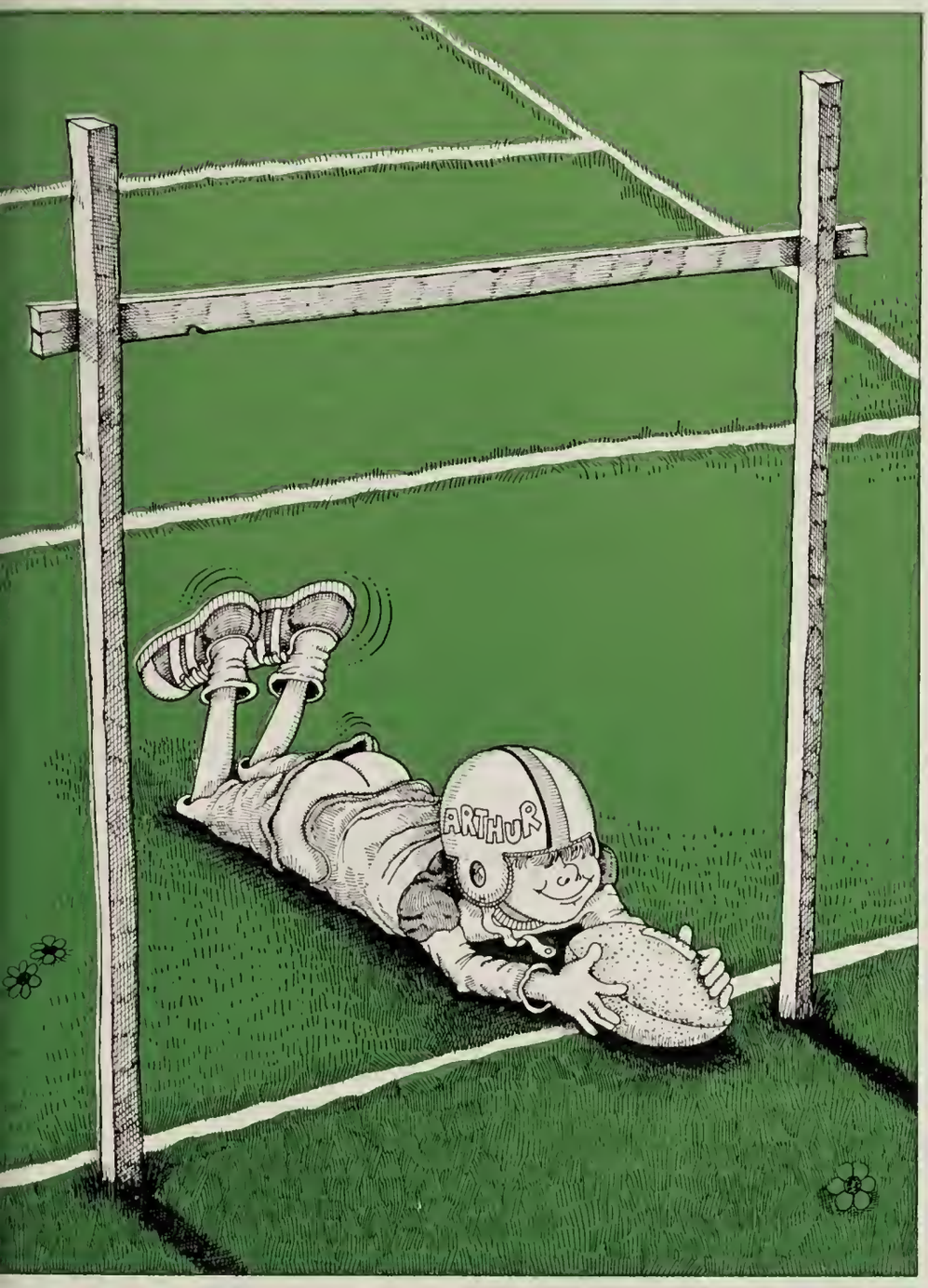
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer

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WORMS BLITZED



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(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

Please see prescribing information on facing page.

Emergency Physicians Seek Abstracts

Original papers for presentation at the ACEP Scientific Assembly (Nov. 4-6, 1974) in Washington, D. C. are now being sought by the Section on Education.

Dr. Ronald L. Krome has set a June 30 deadline for submission of abstracts, and final papers must be in the committee's hands no later than Aug. 30.

To be considered for presentation, papers must be the original and unpublished work of the author, and must be directly related to some aspect of emergency medicine. Papers will be considered for publication in JACEP.

Abstracts must be no longer than 500, nor shorter than 250, words. They must indicate in some detail the contents of the paper. Five copies are to be submitted with the name and address of the presenter. The presentation cannot take any longer than 10 minutes.

Persons interested in this program should contact Dr. Krome, Chairman, Section on Education, American College of Emergency Physicians, 241 East Saginaw Street, East Lansing, Mich. 48823.

Annual Ob-Gyn Seminar Set for Asheville

The 20th Annual Ob-Gyn Seminar will be held again this year in Asheville, N. C., at the Grove Park Inn, July 21-July 26.

A wide variety of subjects in obstetrics and gynecology will be presented and program participation will include faculty from the medical schools of North Carolina, Duke, Bowman Gray and the Medical College of Virginia, in addition to outstanding speakers from other areas.

For registration information, please contact the Secretary, Dr. George T. Schneider, 1514 Jefferson Highway, New Orleans, La. 70121.

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832 South Cooper
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1974, Vol. XV, No. 4

ORIGINAL PAPERS

Stress Ulceration

ANTHONY B. PETRO, M.D.
Jackson, Mississippi

Acute stress ulceration is a serious complication and the syndrome includes a group of acute gastrointestinal ulcerations with diverse clinical settings. The author, a surgery resident, defines stress ulceration, discusses the clinical setting in which it occurs, gives the pathogenesis, therapy, prophylaxis, medical and surgical treatment.

ACUTE STRESS ulceration is a serious complication and presents a formidable threat to a patient already desperately ill. The syndrome includes a group of acute gastrointestinal ulcerations with diverse clinical settings. The increasing incidence is a reflection of awareness and the higher salvage of critically ill patients who subsequently develop a stress ulcer.

It is important to emphasize that this is a different clinical and pathological entity from chronic peptic ulcers that exacerbate under stress. The stomach and duodenum appear to be target organs, but the same process may involve the entire gastrointestinal tract. The pathological findings will vary from epithelial necrosis and superficial erosions to definite ulcer craters to diffuse hemorrhagic necrosis. These ulcers demonstrate no fibrosis or signs of chronicity but are acute ulcerations.

The Problem and Clinical Setting. It is stated that approximately 5 per cent of patients in intensive care units will develop stress ulceration. Many factors probably combine to produce this complication and the following have all been associated with stress ulcers and all may coexist in the same patient:

(1) The postoperative patient who has had more drastic surgery is at a high risk. The majority of stress ulcers occurs in this group.

(2) Up to 50 per cent of patients have been hypotensive at some stage prior to their hemorrhage.

(3) Infection is present in 50-70 per cent of the cases.

(4) The incidence of stress ulceration increases with more significant trauma. Attendant hypotension and sepsis increase the risk.

(5) The burn patients, and especially those with burns over 40-50 per cent of the body, are at an increased risk of gastrointestinal hemorrhage. Some would separate these but they have many features in common with the other stress ulcers.[1-3]

(6) Patients with head trauma, intracranial surgery, brain tumors or other causes of increased intracranial pressure are at an increased risk of gastrointestinal hemorrhage. These patients do demonstrate absolute hyperacidity.[4]

(7) Uremia.

(8) Hypoxia and hypercarbia.

(9) Hepatocellular jaundice.

(10) Ulcerogenic medicines.

The usual patient presents with one or more of the above conditions. The initial manifestations are hypotension, hematemesis or red blood per nasogastric tube; however, the bleeding may present as melena. In the usual case there are no premonitory signs or symptoms. The stress ulcer may present as a perforation, with pain as the initial symptom.

Pathogenesis. The varied clinical settings suggest that many pathways may lead to a similar end result. Focal necrosis has been demonstrated throughout

From the Department of Surgery, University of Mississippi Medical Center, Jackson, Miss.

the gastrointestinal tract. The stomach and duodenum appear as target organs and this is probably related to the acid present in the stomach. Although absolute hyperacidity is not present in the majority of patients studied, increased back diffusion of hydrogen ions through the gastric mucosa may be important. Strikingly increased rates of back diffusion were demonstrated in one-half of the seriously ill patients studied by Skillman and Silen.[5] Thus it would seem that the normal mucosal barrier is disrupted in at least some patients with stress ulceration. Disruption of this barrier may occur in many ways and the following have been shown to do so:

(1) Hypotension and shock—Lucas and others have recently utilized endoscopy to closely follow patients under stress and during shock or hypotension, and they noted an early pallor and mottling of the mucosa of the stomach which they attributed to ischemia secondary to splanchnic vasoconstriction.[6] After the hypotension and restoration of the blood pressure, they noted a picture ranging from edema to diffuse mucosal hemorrhage to frank infarction. The end result was cell damage with subsequent impairment of the mucosal barrier and increased back diffusion of hydrogen ions. This influx exposes the underlying mucosal cells to the deleterious effects of an abnormally high ion flux. The same findings have also been demonstrated in burn patients who subsequently develop Curling's ulcer.

(2) Bile salt regurgitation—The bile salts have been shown to disrupt the mucosal barrier with subsequent increased back diffusion of hydrogen ions.[7] They, too, have been shown to greatly increase acid output from denervated stomachs.[8] Noteworthy is the fact that ileus and gastric stasis and subsequent regurgitation of bile are frequently observed in patients who subsequently develop gastric ulceration.

(3) Qualitative and/or quantitative abnormalities of mucus—anything that adversely affects mucus production, either quantitatively or qualitatively, will expose the mucosal cells to abnormally high acid and digestive enzymes. Menguy has shown that exogenous ACTH and cortisone will decrease the production of mucus and alter the mucopolysaccharide constituents (decreased sialic acid, hexosamine, hexose).[9] They will also increase the time required for regeneration of gastric cells (normal approximately three days). The above results in decreased resistance of mucus to peptic and tryptic proteolysis. The role of steroids in the pathogenesis of stress ulceration is not known at present. Stremple demonstrated an increasing amount of gastric muco-substances in the first few days post trauma and no increase in 17-hydroxycorticosteroids.[22]

(4) Urea nitrogen—Urea has been demonstrated to disrupt the mucosal barrier with resultant increased back diffusion of hydrogen ions. Thus significant azotemia may constitute an additive factor in some critically ill patients.

(5) Vitamin A deficiency—Vitamin A plays a vital role in maintaining the integrity of the mucous-secreting cells of the gastrointestinal tract and deficiency causes these cells to degenerate and shed.[10] Chernov, Nole and Wood have shown that serum Vitamin A levels drop drastically in the severely ill patient, and they contend that high dose Vitamin A prophylactically reduces the risk of gastrointestinal ulceration in the severely injured patient.[11, 21]

(6) Ulcerogenic medicines—In most series of patients there is no direct conclusive correlation between drugs and bleeding. The drugs implicated include steroids, aspirin, reserpine, butazolidin and other anti-inflammatory preparations. Some physicians, however, do not hesitate to utilize steroids in a patient with stress ulcers who has sepsis and shock.

Therapy. At one time stress ulceration was a universally fatal disease and, even with early recognition and therapy, the mortality rate still ranges from 35 to 65 per cent.[16, 17] The mortality from stress ulceration per se is hard to determine since many such patients succumb to their primary illness.

There are no absolute guidelines to treatment of stress ulceration, but available prophylactic measures should be employed in patients who are at high risk.

Prophylaxis.

(1) Treat the primary illness and its attendant sepsis, hypotension, hypoxia.

(2) Antacids should be employed at the earliest possible time.

(3) Gastric stasis should be alleviated if present by utilization of nasogastric suction. Nasogastric suction should not be employed without stasis because the tube will traumatize the gastric mucosa.

(4) Prophylactic Vitamin A (100-400,000 units/day).

(5) Avoidance of ulcerogenic medicines.

Medical Treatment. After hemorrhage has commenced one initially utilizes iced saline lavages, fluids and blood. Recently intragastric and intraperitoneal pitressin and/or norepinephrine have been

utilized.[12] Also selective arterial cannulation and infusion of pitressin and/or norepinephrine or epinephrine and propanolol have been utilized and initially appear promising.[12–15] Hopefully they will play a larger and larger role. Fresh blood should be utilized for most of these patients have impaired liver function and diminished clotting factors which are easily depleted with old blood.

Surgical Treatment. If the massive hemorrhage does not promptly stop or massive rebleeding occurs, one should not procrastinate about surgery for this results in a sicker patient who is an even poorer operative risk.

The initial part of the operation is a careful examination of the entire stomach and duodenum for the ulcers may occur from the cardioesophageal angle to the duodenum and may be multiple. Upon assessment of the problem one must next decide the optimal operation for his patient. In this surgical setting the simplest and most expedient operation that will halt hemorrhage and salvage the patient is the desired one. From this point there is a divergence of opinions which may in part be related to the different clinical settings and operative findings.

Those who advocate vagotomy, pyloroplasty and oversewing of the ulcers maintain that this is accomplished with less mortality than a gastric resection.[16, 18] Recurrent hemorrhage is thought by others to prohibit anything less than a subtotal gastric resection.[6, 17, 19] Most surgeons employ a vagotomy with a subtotal gastric resection and also include the ulcers in the resection. With multiple ulcers or acute erosive hemorrhagic gastritis, a near total or total gastrectomy is often employed.

Individualization would seem imperative when there is such a gamut of clinical presentations of stress ulceration. A single acute bleeding ulcer would seem amenable by a vagotomy, pyloroplasty and oversewing of the ulcer. However, in the face of multiple ulcers and/or hemorrhagic gastritis, one might easily surmise that an initial resection to include the ulcers and the majority of the gastritis is indicated.

If hemorrhage recurs after vagotomy, pyloroplasty, and oversewing of an ulcer crater, one is more aggressive about reoperation and gastric resection. If a high subtotal resection and vagotomy was the initial operation, one obviously tries to cease recurrent hemorrhage medically.

At this junction one cannot categorically state that a particular operation is "the operation" for stress ulceration. We must note the degree of hemorrhage and operative findings and correlate these with the operation performed and ultimate salvage of the patient and the incidence of recurrent hemorrhage. ★★★

2500 North State Street (39216)

REFERENCES

1. O'Neill, J. A., Pruitt, B. A., Moncrief, J. A. and Switzer, W. G.: Studies Related to the Pathogenesis of Curling's Ulcer, J. Trauma 7:275-285, 1967.
2. Pruitt, B. A., Foley, F. D. and Moncrief, J. A.: Curling's Ulcer: A Clinical-Pathologic Study of 323 Patients, Ann. Surg. 172:523-539, 1970.
3. O'Neill, J. A.: The Influence of Thermal Burns on Gastric Acid Secretion, Surg. 67:267-271, 1970.
4. Norton, L., Green, J. and Eiseman, B.: Gastric Secretory Response to Head Injury, Arch. Surg. 101:200-204, 1970.
5. Skillman, J. J., Gould, S. A., Chung, R. and Silen, W.: The Gastric Mucosal Barrier: Clinical and Experimental Studies in Critically Ill and Normal Man, and in the Rabbit, Ann. Surg. 172:564-594, 1970.
6. Lucas, C. E., Sugawa, C., Friend, W. and Walt, A. J.: Therapeutic Implications of Disturbed Gastric Physiology in Patients With Stress Ulcerations, Amer. J. Surg. 123:26-34, 1972.
7. Hauza, K. N. and Den Bloten, L.: Bile Salts Producing Stress Ulcers During Experimental Shock, Surg. 71:161-167, 1972.
8. Nahrwold, D. L.: Bile as a Gastric Secretory Stimulant, Surg. 71:157-160, 1972.
9. Menguy, R. and Masters, Y. E.: Effect of Cortisone on Mucoprotein Secretion by Gastric Antrum of Dogs: Pathogenesis of Steroid Ulcers, Surg. 54:19-28, 1963.
10. DeLuca, L. and Wolf, G.: Vitamin and Protein Synthesis in Mucous Membranes, Amer. J. Clin. Nutr. 22: 1059, 1969.
11. Cheanov, M. S., Hale, H. W. and Wood, M.: Prevention of Stress Ulcers, Amer. J. Surg. 122:674-677, 1971.
12. Leveen, H., Falk, G., Diaz, C., Wynkoop, B. S., Piccone, V., Yarnoz, M., Langsam, A., Nelson, J. H., Pedowitz, W. J. and Belfasky, R. B.: Control of Gastrointestinal Bleeding, Amer. J. Surg. 123:154-159.
13. Morello, D., Klein, N., Wolferth, C. and Matsumoto, T.: Management of Diffuse Hemorrhage From Gastric Mucosa. II. Effects of Selective Intra-arterial Infusion of Vasopressin and/or Epinephrine, Amer. J. Surg. 123: 160-164, 1972.
14. Baum, S., Nusbaum, M. and Tumen, H. G.: The Control of Gastrointestinal Hemorrhage by Selective Mesenteric Arterial Infusion of Pitressin, Gastroenterology 58:926, 1970.
15. Rosch, J., Dotter, C. T. and Rose, R. W.: Selective Arterial Infusions of Vasoconstrictors in Acute Gastrointestinal Bleeding, Radiology 99:27, 1971.
16. Kurtley, J. A., Scott, H. W., Sawyers, J. L., Graves, H. A. and Lawler, M. R.: The Surgical Management of Stress Ulclers, Ann. Surg. 169:801-808, 1969.
17. Menguy, Gadacz, Zajtchuk: The Surgical Management of Acute Gastric Mucosal Bleeding, Arch. Surg. 99: 198-208, 1969.
18. Byrne, Guardione: Surgical Treatment of Stress Ulcers, Amer. J. Surg. 125:464-467, 1973.
19. Crawford, F. A., Hammon, J. W. and Shingleton, W. W.: The Stress Ulcer Syndrome: A Clinical and Pathological Review, Amer. J. Surg. 121:644, 1971.
20. Taylor, P., Loop, F. and Hermann, R.: Management of Acute Stress Ulcer After Cardiac Surgery, Ann. Surg. 178:1-5, 1973.
21. Chernov, M., Cook, F., Wood, M. and Hale, H.: Stress Ulcer: A Preventable Disease, J. Trauma 12:831-833, 1972.
22. Stremple, J., Mori, H., Lev, R. and Glass, G.: The Stress Ulcer Syndrome, Current Problems in Surgery (April) 1973.

Case Report XVII of Maternal Mortality Study

W. E. GODFREY, II, M.D.
Natchez, Mississippi

THE FOLLOWING case report represents a maternal death in a 17-year-old, gravida II, para I, female due to unrecognized ruptured ectopic pregnancy.

This is the case report of a 17-year-old black female, Gravida II, Para I, who died suddenly after being admitted to the hospital for low abdominal pain and temperature elevation. The committee reviews the case, rates it as avoidable, and discusses diagnosis and treatment of tubal pregnancies, including three diagnostic pitfalls.

CASE NO. 740-71

A 17-year-old black gravida II, para I, presented with a chief complaint of low abdominal pain of two days' duration. She stated that her last normal menstrual period had occurred two weeks earlier. There was no history of contraception. Prior medical and obstetrical history was recorded as "noncontributory." Pertinent physical findings were a temperature of 98 degrees F., blood pressure of 110/70, and pulse of 90; in addition, she had "peritoneal signs in low abdomen," severe uterine and adnexal tenderness, but no palpable mass. The only laboratory findings recorded were a hematocrit of 31 per cent and a negative HCG.

After an unspecified time interval, the patient's temperature rose to 101 degrees F. She was then admitted to the hospital and treatment was begun with intravenous Ampicillin. She suddenly expired six hours later.

An autopsy was performed and revealed blood in the peritoneal cavity and a ruptured tubal pregnancy of approximately six weeks' gestation.

This case was reviewed anonymously by the MSMA Committee on Maternal and Child Care at a regular, quarterly meeting of the committee. The adequancy of the information received was rated as 3 on the ascending scale of 1 to 5. The committee felt that this death should be classified as an avoidable obstetrical death due to ruptured ectopic pregnancy. The adequacy of evaluation of this patient is difficult to measure because of lack of information. But, certainly severe lower abdominal pain in an anemic, afebrile young female of child-bearing age should always arouse a high degree of suspicion that the patient might have a ruptured tubal pregnancy.

DISCUSSION

Ectopic pregnancy is estimated to occur approximately once in every 150 pregnancies. It is further estimated that it is responsible for two to three per cent of all obstetrically-caused maternal deaths in the United States each year. Therefore, all of us who deal with women in the child-bearing age must remain "ectopic conscious" if these tragedies are to be prevented.

The diagnosis of ruptured ectopic pregnancy is relatively easy to make in the individual who presents with the classical signs and symptoms: (1) a history of "pelvic infection" and patient has missed her last normal menstrual period and then has the sudden onset of vaginal bleeding, severe lower abdominal pain associated with a syncopal episode;

Obstetrics and Gynecology member, Committee on Maternal and Child Care.

(2) examination reveals an afebrile shocky woman who has the signs of peritoneal irritation, a bulging cul de sac, and perhaps, an adnexal mass, and (3) laboratory reports of a positive pregnancy test and a lowered hemoglobin. If all the above occur, then a diagnosis of ruptured ectopic pregnancy will be rapidly made, and she will be transfused and quickly explored.

This case underscores three of the diagnostic pitfalls that can mislead the physician and can cost the patient her life. These are:

(1) A third or so of all patients with an ectopic pregnancy have had some bleeding about one month after their last normal menstrual period, and are, therefore, unaware that they are pregnant.

(2) A positive HCG test can be helpful, but a negative test means only that there is no functioning chorionic tissue, or the titer is too low to be detected, or the test is a false negative.

(3) A temperature elevation does not rule out ectopic pregnancy since blood in the peritoneal cavity can elicit a febrile response (and also a leucocytosis), or the patient might have other causes of fever, such as pharyngitis, etc.

Therefore, it is strongly recommended that women who might have a ruptured tubal pregnancy should have appropriate diagnostic measures performed including where indicated, culdocentesis. Culdocentesis requires no special equipment and can be done almost anywhere a patient can be examined. While a negative tap does not rule out a tubal pregnancy, a syringe full of nonclotted blood leaves no doubt as to the necessity for prompt intervention.

The treatment for ruptured tubal pregnancy involves primarily rapid blood replacement and prompt laparotomy.

SUMMARY

A maternal death due to an unrecognized tubal pregnancy has been presented. The Committee on Maternal and Child Care feels that this is a preventable death. A plea is made that physicians be "ectopic conscious," since this disease is so treatable if diagnosed and so deadly if unrecognized. ★★★

136 Jeff Davis Blvd. (39120)

The old farmer was in the city and attended church on Sunday morning. He admired the stained glass windows, deep carpet and beautiful pipe organ, then settled down to enjoy the service. When the minister said something he approved of, he thundered loudly, "A-men!"

An usher strode down the aisle, tapped him on the shoulder, and whispered, "Sshhh, be quiet!"

Soon, it happened again. "Amen!"

Back came the usher. "I must ask you to be quiet. We don't allow that."

"But, I've got religion!" the old man protested.

The usher retorted, "Well, you didn't get it here!"

Radiologic Seminar CXXXVIII: The Battered Child

JUNE G. BLOUNT, M.D.
Jackson, Mississippi

In 1946, Caffey described a syndrome in which subdural hematoma was associated with fractures of the long bones, often multiple, or repetitive, and in varying stages of repair.[5]

In 1961, Kempe coined the term "The Battered Child" for the abused or traumatized child.[5] Maltreatment of infants and young children may cause multiple injuries, including soft tissue, skeletal, abdominal, and head injuries. Subdural hematoma and cerebrospinal injuries are the most serious and urgent complications of the syndrome, and the principal causes of both death and permanent disability.[2] Combined injuries and evidence of prior injury are common. History is confusing or evasive.

The majority of patients are less than two years of age and they commonly show signs of deprivation.

The strongest evidence that the child has been abused is the presence of multiple fractures in various stages of healing, indicative of multiple traumatic injuries inflicted at different times.[2, 4]

RADIOGRAPHIC SIGNS OF TRAUMA TO GROWING BONES

Radiologic recognition of characteristic signs of skeletal injury is a helpful guide to establishing the diagnosis of physical abuse.[4] The roentgen examination not only discloses the traumatic origin of the lesions, but also their number, sites, approximate ages, and progressive changes.[2] Roentgen examination of the skull and long bones is indicated in "accident-prone" children. Radiographic changes are often present in the absence of local clinical signs.[4] The absence of skull fracture does not preclude the presence of a life-endangering intracranial hemorrhage.

The outstanding skeletal findings are related to bone injury and repair:

(1) *Cortical Metaphyseal Fragmentation.* The cortical metaphyseal fragments are present immediately following the injury and permit the immediate radiographic diagnosis of trauma.[1] Metaphyseal infractions may be complete transverse metaphyseal fractures or chip cortical fracture fragments which are pulled off the cortical wall at the level of the metaphyses (the "corner" fragment). Fragments vary in size, but are usually small and few in number, only minimally displaced, and are frequently devoid of local pain, swelling and heat. The most common locations are at the knees and ankles, but may be found at the metaphyses of almost all the



Figure 1. Cortical Metaphyseal Fragmentation. There is a small chip fracture of the medial aspect of the distal femoral metaphysis, a "corner fragment." This 7-month-old boy presented with a history of falling 2 days ago and refusal to support weight on this leg. (Retouched print.)

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From the Department of Radiology, University Medical Center, Jackson, Miss.

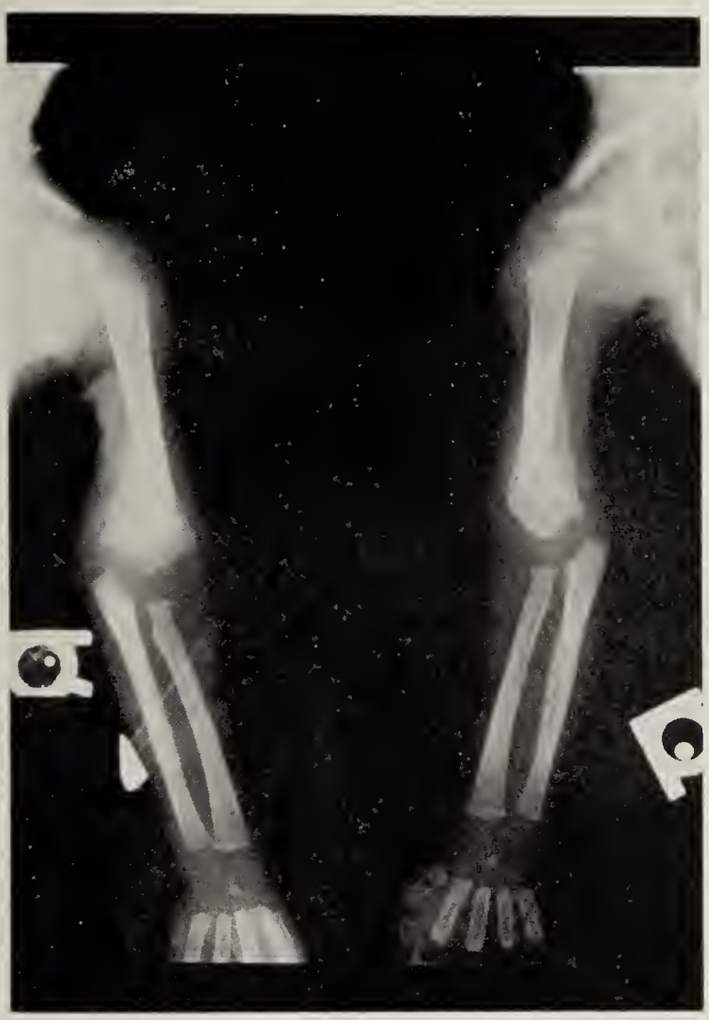


Figure 2. Traumatic involucrums in a 10-month-old admitted with multiple bruises and subdural hematoma. Exuberant subperiosteal new bone of both distal humeri.

tubular bones. They appear to be the most valuable single diagnostic radiographic feature in the battered child syndrome[2] (see Figure 1).

(2) *Traumatic Involucrums* (external cortical thickenings). These extra shells of cortical thickenings are the largest of all infantile traumatic lesions. They do not become visible radiographically until 7 to 14 days after injury. They are often found with metaphyseal fragmentation, although the shaft need not be fractured. At first, they are subperiosteal hematomas, casting para-osteal images of water density only. The periosteum is loosened from the underlying cortical bone, and blood accumulates beneath it. As the bleeding stops, the blood begins to be resorbed and the elevated subperiosteal bony shells thicken progressively. These thickenings gradually diminish, but have been known to have remained visible for longer than 10 years[2] (see Figure 2).

(3) *"Bucket Handle"* images at the ends of the shaft represent extensions of traumatic involucrums beyond the end of the shaft, around the end of the metaphysis. This feature is diagnostic of injury[3] (see Figure 3).

(4) *Traumatic Metaphyseal Cuppings* develop slowly and are usually not diagnostic until after many weeks or several months.[1] Longitudinal growth is retarded secondary to reduced blood flow through the injured epiphysis, while the peripheral rim of cortex continues to grow more rapidly, leading to central cupping. The epiphyseal ossification center overgrows at the same time and fuses prematurely with the metaphysis.[2]

(5) *Epiphyseal Separation* (see Figure 4).

(6) *Ectopic Accessory Epiphyseal Ossification Centers* in the injured cartilaginous epiphyses, in which ossification centers do not normally develop.

(7) *Traumatic Bowing* of the ends of the diaphyses.

(8) *Multiple Fractures* in different stages of healing. Spiral fractures of the mid humerus and femur are common. Fractures have been found in the skull, ribs, long bones, vertebrae, clavicle, facial bones, mandible, scapula.

(9) *Skull Fractures, Subdural Hematoma and Cerebrospinal Injuries* are the most serious and urgent complications of the syndrome and the principal causes of both death and permanent crippling (see Figure 5).

Subdural hematomas have been found with and without fractures of the long bones. Subdural hematomas have been present in 10-25 per cent of patients who have had multiple injuries to the long bones.[1]

TYPES OF INJURY

The fracture pattern reflects the type of forces to which the child has been subjected. Most of the



Figure 3. "Bucket Handle" metaphyseal fracture at the proximal end of the femur. Same 10-month-old as shown in Figure 2.

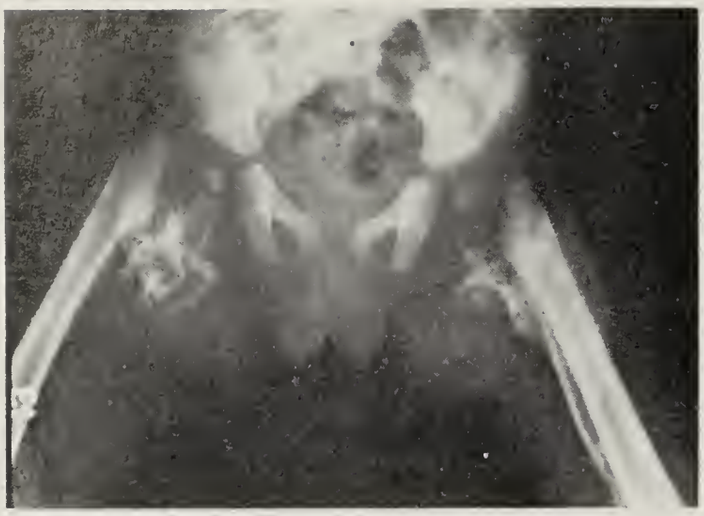


Figure 4. Epiphyseal separations at both hips are defined by the ossification center for each head, which remains within the acetabular fossas, the femoral shafts displaced laterally.



Figure 5. Linear skull fracture of the right parietal bone with associated hematoma, in a 4-month-old child.

skeletal lesions result from traction, stretching stresses and shearing forces, tension and torsion forces. In general, the common locations and the type of fracture suggest a violent twist or jerk to the extremity, or shaking the child while he is held suspended by an arm or leg.[4]

The twisting force to the extremity accounts for the spiral fracture of the humerus or femur. A sudden pull on the arm or leg is likely to separate the epiphysis from the metaphysis. A violent shaking of the child while suspended by the arm or leg can produce subperiosteal and subchondral bleeding at the level of the epiphyseal plate, followed by callus formation.[4]

Whiplash stresses on the head and neck, as well as skull fracture, account for subdural hematoma and cerebral contusions.

In growing long bones the periosteum is tightly anchored at both ends by heavy extensions into the epiphyseal cartilages. The highly vascularized young periosteum is loosely attached to its underlying cortical shaft, and is easily torn from it. Free subperiosteal bleeding is common, lifting the bone-forming layers away from the cortex to form an external shell of new bone.[1]

The tighter terminal attachments of the periosteum in the terminal segments of the shaft and perichondrium and the contiguous epiphyseal cartilage are responsible for avulsion of the metaphyseal fragments.[1]

Astley found that metaphyseal lesions caused surprisingly little pain or tenderness. He found that most fractures were not detectable on the physical examination, but became evident after the entire skeleton had been examined radiographically.[2]

DIFFERENTIAL DIAGNOSIS

Birth injuries, infantile cortical hyperostosis, scurvy, syphilis, osteogenesis imperfecta, congenital indifference to pain, epiphyseal changes in frost bite and electrical burns are considered in the differential diagnosis. Leukemia, metastatic neuroblastoma, hypophosphatasia, or meningococcemia may present with clinical signs and symptoms suggesting a battered child.

SUMMARY

Multiple fractures in different stages of healing, exaggerated periosteal reactions, frequent metaphyseal fragmentation with epiphyseal separation, soft tissue injuries, head injuries, and evidence of prior injury unexplained by history are indicative of a "battered child." Caffey concluded that "the radiographic changes are pathognomonic of trauma, but they never identify the perpetrator of the trauma or his motive."[1, 2] ★★★

2500 North State Street (39216)

REFERENCES

1. Caffey, John: Pediatric X-Ray Diagnosis. Chicago, Year Book Medical Publishers, Inc., 6th Edition, 2:1132-1148, 1972.
2. Caffey, John: The Parent-Infant Traumatic Stress Syndrome, Am. J. Roent., Rad. Ther. and Nucl. Med. 114 (2):218-229 (Feb.) 1972.
3. Murray and Jacobson: The Radiology of Skeletal Disorders. Baltimore, The Williams and Wilkins Co., 1971, p. 149.
4. O'Neill, J. A., Jr., et al: Patterns of Injury in the Battered Child Syndrome, J. Trauma 13 (4):332-339 and 399-400 (April) 1973.
5. Silverman, F. N.: Unrecognized Trauma in Infants, The Battered Child Syndrome, and the Syndrome of Ambroise Tardieu: Rigler Lecture. Radiology 104:337-353 (Aug.) 1972.

106th Annual Session

Mississippi State Medical Association
May 6-9, 1974
Biloxi

MISSISSIPPI'S GULF COAST will become the state's medical capital May 6-9 as the 106th Annual Session of the association gets underway at the Sheraton-Biloxi. Seven scientific specialty sessions, fifteen specialty groups, four medical alumni occasions, technical and scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the four-day meet.

Dr. Arthur A. Derrick, Jr., of Durant, association president, will address the opening meeting of the House of Delegates on May 6. House Speaker John B. Howell, Jr., of Canton and Vice Speaker Walter H. Simmons of Jackson said that reports and resolutions will be presented at the opening meeting. Final actions will come on May 9 when 1974-75 officers are elected.

Dr. J. T. Davis of Corinth will be inaugurated president for the new year during closing ceremonies on the final day.

Dr. James P. Spell of Jackson said that the Scientific Assembly will open on Tuesday morning, May 7, and continue through Thursday noon. The Scientific Assembly has been approved for 14 hours AMA Physician Recognition Award credit and MAFP prescribed credit. Dr. Spell heads the group which has planned and scheduled the general and specialty sessions, exhibits, and fellowship occasions.

Principal speaker for the annual session is Dr. Russell B. Roth of Erie, Pa., president of the American Medical Association. He is scheduled to address the opening meeting of the House of Delegates on May 6, Dr. Derrick said.

The Woman's Auxiliary will conduct its 51st Annual Session concurrently during May 6-8, also headquartering at the Sheraton-Biloxi, according to Mrs. W. H. Preston, Jr., of Booneville, state president. Mrs. Dan Reikes of Hattiesburg will be inaugurated 1974-75 president at the meeting. General chairman for the ladies' meet is Mrs. Jack A. Stokes of Pontotoc.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 106th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Monday, May 6, 1974, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Sheraton-Biloxi on May 6.

The Scientific Assembly, consisting of the seven general sessions, will meet during May 7-9, 1974.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

ARTHUR A. DERRICK, JR.
PRESIDENT

JAMES P. SPELL
SECRETARY-TREASURER

Medical alumni occasions are set for Monday and Tuesday evenings, and the association cocktail party and fellowship hour is the Wednesday feature.

The Sheraton-Biloxi luxury hotel will again host the annual session. Located immediately east of the Broadwater Beach Hotel, the relatively new complex consists of a nine-story tower fronting on the Gulf with five connected two- and three-story lanai units on the north or back. Reservations at the Sheraton are being made through MSMA; if additional rooms are needed, reservations will be made at the adjacently-sited Ramada Inn and Holiday Inn.

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Paul B. Brumby, Lexington	1970-71
Arthur E. Brown, Columbus	1971-72
Charles R. Jenkins, Laurel	1972-73

ACTIVITIES CALENDAR

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located at the second level (Grand Ballroom and Gulf Rooms) in the Sheraton-Biloxi. No person may be admitted to any activity of the annual session without first registering. Hours of registration will be 2:00 to 4:00 p.m., Sunday, May 5, 1974; 8:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday, May 6, 7, and 8; and 8:00 a.m. to 1:00 p.m., Thursday, May 9. The secretary's office will be located off the arcade on the first level lobby.

SUNDAY, MAY 5, 1974

10:30 a.m. Miss. Dermatological Society Organizational Meeting, Boston Room
1:00 p.m. Urology for the Primary Physician Course, Gulf Room C
2:00 p.m. Miss. Association of Pathologists, Business Meeting, Biloxi Room
2:00 p.m. Auxiliary Hospitality Area and Registration, First Floor Lobby
2:00 p.m. MSMA Registration, Second Level Lobby
5:30 p.m. Urology Course Cocktail Party, Gulf Room D
6:00 p.m. Miss. Society of Anesthesiologists Cocktails and Dinner, Gulf Room B

MONDAY, MAY 6, 1974

7:00 a.m. Reference Committee Breakfast, Gulf Room D
9:00 a.m. House of Delegates, Top of the Sheraton
9:00 a.m. Miss. Association of Pathologists, Scientific Meeting, Biloxi Room
9:00 a.m. Miss. Neurosurgical Society, Scientific Session, Gulf Room C
10:30 a.m. Woman's Auxiliary Finance Committee Meeting, Jackson Room
12:00 noon Miss. Orthopaedic Society Luncheon, Gulf Room D
12:00 noon Miss. Neurosurgical Society Luncheon, Boston Room
1:30 p.m. Reference Committee on Reports of Officers and Board of Trustees, Gulf Rooms A and B
1:30 p.m. Reference Committee on Miscellaneous Business, Gulf Room C
2:00 p.m. Miss. Commission on Hospital Care Meeting, Biloxi Room
2:30 p.m. Woman's Auxiliary Preconvention Board Meeting, Jackson Room
3:30 p.m. Reference Committee on Medical Practices, Gulf Room D
3:30 p.m. Council on Constitution and By-Laws, Gulf Room C
4:00 p.m. Ole Miss Medical Alumni Business Meeting, Boston Room
4:30 p.m. Woman's Auxiliary Coffee Honoring Unit Presidents, Poolside

7:00 p.m. Ole Miss Medical Alumni Cocktail Party, Top of the Sheraton
8:00 p.m. Ole Miss Medical Alumni Seafood Jamboree and Dance, Top of the Sheraton

TUESDAY, MAY 7, 1974

8:00 a.m. MSMA General Membership Breakfast, Top of the Sheraton
8:30 a.m. Woman's Auxiliary Continental Breakfast, Gulf Rooms C and D
9:00 a.m. General Scientific Session, Grand Ballroom
9:30 a.m. Woman's Auxiliary General Session, Gulf Rooms C and D
12:00 noon American College of Surgeons Luncheon, Gulf Rooms A and B
12:00 noon Miss. Ob-Gyn Society Luncheon, Biloxi Room
12:00 noon Fifty Year Club Luncheon, Boston Room
1:00 p.m. Woman's Auxiliary Luncheon, Top of the Sheraton
2:00 p.m. American College of Surgeons Scientific Program (to be followed by case reports and a business meeting), Gulf Rooms C and D
2:00 p.m. General Scientific Session, Grand Ballroom
3:30 p.m. Woman's Auxiliary Postconvention Board Meeting, Jackson Room
3:30 p.m. Woman's Auxiliary Film Presentation, Gulf Room B
4:00 p.m. Tonometry Course, Gulf Room A
5:30 p.m. Vanderbilt Medical Alumni Cocktail Party, Jackson Room
6:00 p.m. Tulane Medical Alumni Reception, Gulf Room B
6:00 p.m. Tennessee Medical Alumni Banquet, Gulf Rooms C and D
7:00 p.m. Flying Physicians Association Dinner, Grand Ballroom

WEDNESDAY, MAY 8, 1974

7:30 a.m. MSMA Past Presidents' Breakfast, Boston Room
8:30 a.m. Woman's Auxiliary Past Presidents' Breakfast, Jackson Room
9:30 a.m. General Scientific Session, Grand Ballroom
10:00 a.m. Woman's Auxiliary Film Presentation, Gulf Room B
12:00 noon Miss. Academy of Family Physicians Luncheon, Top of the Sheraton
12:30 p.m. Miss. Society of Internal Medicine Luncheon, Gulf Room B
1:30 p.m. Nominating Committee, Gulf Room A
1:30 p.m. General Scientific Session, Grand Ballroom
3:00 p.m. General Scientific Session, Grand Ballroom
4:00 p.m. Tonometry Course, Gulf Room A
7:00 p.m. MSMA Fellowship Party, Poolside

THURSDAY, MAY 9, 1974

9:30 a.m. General Scientific Session, Grand Ballroom
9:30 a.m. General Scientific Session, Gulf Room A
12:00 noon Miss. EENT Association Luncheon, Gulf Room B
1:30 p.m. House of Delegates, Top of the Sheraton

EXECUTIVE BUSINESS



DR. HOWELL

HOUSE OF DELEGATES

May 6, 1974
9:00 a.m.

Sheraton-Biloxi

John B. Howell, Jr.
Canton, Speaker

Walter H. Simmons
Jackson, Vice Speaker



DR. SIMMONS

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the Speakers will announce the order of business. An open meeting on May 6, to which all members and ladies of the Auxiliary are invited, will feature addresses by Dr. Arthur A. Derrick, Jr., the president, and Dr. Russell Roth, president of the American Medical Association. The adjourned meeting of the House will convene at 1:30 p.m. on May 9.

REFERENCE COMMITTEES

Reports of Officers and Board of Trustees, May 6, Gulf Rooms A and B, 1:30 p.m.
Miscellaneous Business, May 6, Gulf Room C, 1:30 p.m.
Medical Practices, May 6, Gulf Room D, 3:30 p.m.
Constitution and By-Laws, May 6, Gulf Room C, 3:30 p.m.
Nominating Committee, May 8, Gulf Room A, 1:30 p.m.

THE SCIENTIFIC ASSEMBLY



DR. SPELL

COUNCIL ON SCIENTIFIC ASSEMBLY

JAMES P. SPELL, Chairman

THE COUNCIL

LEE H. ROGERS, Chairman, EENT
JAMES W. RAYNER, Secretary
WILLIAM M. GILLESPIE, JR., Chairman, Family Practice
W. BOYCE WHITE, Secretary
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JOE M. ROSS, JR., Secretary
WALTER L. BOURLAND, Chairman, Ob-Gyn
CHARLTON R. VINCENT, Secretary
FRANK M. WIYGUL, JR., Chairman, Pediatrics
ROBERT L. ABNEY, III, Secretary
RUBY B. GRIFFIN, Chairman, Preventive Medicine
STEVEN L. MOORE, Secretary
H. RICHARD JOHNSON, Chairman, Surgery
HENRY B. TYLER, Secretary

MEDICAL TELEVISION

A selected group of films which supplement presentations from the scientific assembly will be shown. Davis and Geck Suture Company is in charge of the film presentations.

SCIENTIFIC AND TECHNICAL EXHIBITS

Grand Ballroom, Sheraton-Biloxi

CONDUCT OF THE SCIENTIFIC ASSEMBLY

The order of exercise, papers, and discussion as set forth in the official program shall be followed until completion. All papers read before the association shall become its property. Each paper must be read by its author and deposited with the Secretary (or Chairman) when read.

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations, and major medical institutions will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award given for excellence of presentation, quality of content, and originality. Others may not participate in this competition, but they are eligible for the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. The Scientific Exhibit is located in the Grand Ballroom.

EXHIBITS AND AUTHORS

"Cardiovascular Surgery"
James D. Hardy, Akio Suzuki, Carlos M. Chavez and Seshadri Raju, Department of Surgery, University Medical Center, Jackson

"Naso-Fronto-Ethmoidal Injuries"
Division of Otolaryngology, University Medical Center, Jackson

"Early Recognition of Oral Cancer"
Michael E. Jabaley, and R. L. Clement, Division of Plastic Surgery, University Medical Center, Jackson

"Clinical Application of Echocardiogram"
McKamy Smith and H. Davis Dear, Jackson

"Heart Pacemakers: New Developments and Perspectives"
William R. Fain, Carlos M. Chavez and J. Harold Conn, V. A. Center, Jackson

"Contour Surgery in Cleft Lip and Palate Deformity"
W. Douglas Godfrey, Jackson

"Neuro-Otologic Diagnosis and Treatment"
James T. Robertson and Gale Gardner, Memphis

"Unusual Aneurysms"
Noel Mills and John L. Ochsner, The Ochsner Clinic, New Orleans

"Intestinal Obstruction in Cystic Fibrosis"
Suzanne T. Miller and Richard C. Miller, Departments of Pediatrics and Surgery, University Medical Center, Jackson

"Recognition and Treatment of Infections in the Newborn"
John E. Rawson and Alfred W. Brann, Jr., Department of Pediatrics, University Medical Center, Jackson

"Functions of a Comprehensive Rehabilitation Unit"
Guy T. Vise, Jr., and George W. Wharton, Jackson

"Mississippi Alcohol Safety Education Program"

"Dyslexia and Learning Disabilities"
Mississippi EENT Association

"Prevent Blindness"
Mississippi Society for the Prevention of Blindness

"Coronary and Valvular Heart Disease—Surgical Treatment"
Thomas L. Kilgore, Jr., and Martin H. McMullan, Jackson

"Vascular Trauma"
Hector S. Howard, H. Edward Garrett, J. T. Davis, Jr., and Charles Stewart, Memphis

"Transplantation of the Kidney"
George V. Smith, Department of Surgery, University Medical Center, Jackson

"American Cancer Society Sho-Kit"
American Cancer Society, Mississippi Division

"Hinds General Hospital Tumor Conference—Direct Patient Benefits"
Edward M. Lowicki, Jack B. Campbell, and Charles E. Farmer, Jackson

"High Blood Pressure"
Mississippi Heart Association

"Combined Steroid-Anti-infective Topical Therapy in Common Dermatoses"
James G. Thompson,* Jackson

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1974 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, or equipment, and in providing varied services, will present the exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The Technical Exhibit is located in the Grand Ballroom.

EXHIBITORS	BOOTH
Ames Company, Elkhart, Ind.	46
Amid Laboratories, Marion, Ala.	41
Bankers Trust Savings & Loan Association, Jackson, Miss.	51
Bedsole Surgical Supply Co., Inc., Mobile, Ala.	66
Blue Cross & Blue Shield of Mississippi, Jackson, Miss.	62
Bristol Laboratories, Syracuse, N. Y.	61
Ciba Pharmaceutical Company, Atlanta, Ga.	56
Comatic Laboratories, Inc., Houston, Tex.	57
Cooper Laboratories, Inc., Parsippany, N. J.	59
Dome Laboratories, Mobile, Ala.	35
The Emko Company, St. Louis, Mo.	31

* Deceased Feb. 23, 1974.

Financial Service Corporation, Jackson, Miss. 65
General Medical, Jackson, Miss. 52
Hillcrest Hospital Birmingham, Ala. 48
Hoechst Pharmaceuticals, Inc., Somerville, N. J. 45
Lakeside Laboratories, Inc., Milwaukee, Wisc. 38
Lanier Business Products, Jackson, Miss. 63
McNees Medical Supply, Jackson, Miss. 64
Mead Johnson Laboratories, Evansville, Ind. 67
Merrill Lynch, Pierce, Fenner & Smith, Inc., Jackson, Miss. . . 69
Meyer Laboratories, Inc., Fort Lauderdale, Fla. 58
Pfizer Laboratories, Doraville, Ga. 44
A. H. Robins Company, Richmond, Va. 37
Sandoz Pharmaceuticals, East Hanover, N. J. 72
Schering Laboratories, Kenilworth, N. J. 55
Stuart Pharmaceuticals, Wilmington, Del. 53
The Travelers Insurance Company, Jackson, Miss. 47
UAD Laboratories, Minden, La. 68
United States Air Force, Dallas, Tex. 32
Wampole Laboratories, Stamford, Conn. 33
Weight Watchers, Jackson, Miss. 54

REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Deposit cards at Registration not later than 4:30 p.m., Wednesday, May 8. Prizes will be awarded at the Association party Wednesday night.

SCIENTIFIC GRANTS

Geigy Pharmaceuticals, Ardsley, N. Y.
Eli Lilly & Company, Indianapolis, Ind.
Merck, Sharp & Dohme, West Point, Pa.
William P. Poythress & Company, Inc., Richmond, Va.
A. H. Robins, Richmond, Va.

ASSISTANCE WITH SCIENTIFIC PROGRAM

These pharmaceutical manufacturers assisted the following sections with their programs:

The Upjohn Company—The Section on Ob-Gyn
Merck Sharp & Dohme and G. D. Searle and Co.—The Section on Medicine
Pfizer Laboratories—The Section on Family Practice
Merck Sharp & Dohme—The Section on Surgery

SCIENTIFIC PROGRAM

Tuesday, May 7, 1974
Grand Ballroom
Beginning at 9:00 a.m.

H. Richard Johnson, Jackson
Chairman

Henry B. Tyler, Jackson
Secretary



DR. JOHNSON

EXPERIENCE WITH TOTAL KNEE ARTHROPLASTY
James O. Manning, Jackson

EVOLUTION OF VAGOTOMY IN THE TREATMENT OF DUODENAL ULCER
John L. Sawyers, Nashville

GRANULOMATOUS COLITIS
George A. Hallenbeck, Birmingham

ANGIOGRAPHY AND EVALUATION OF PANCREATIC DISEASE
Irving F. Hawkins, Miami

SCIENTIFIC PROGRAM

Tuesday, May 7, 1974
Grand Ballroom
Beginning at 2:00 p.m.

Walter L. Bourland, Tupelo
Chairman

Charlton R. Vincent, Laurel
Secretary



DR. BOURLAND

DERANGED FETAL MATURATION

I. Evaluation of Fetal Maturity
Winfred L. Wiser, Memphis

II. Post Mature Syndrome
George Ellis, Memphis

III. Failure of Placental Maturation
Tyler Swindle, Memphis

IV. Panel Discussion
A. Placental Insufficiency from Other Causes
B. Evaluation of Placental Insufficiency Infant
C. Difference in Prognosis
D. Methods of Delivery

SCIENTIFIC PROGRAM



DR. MCDONNIEAL

Wednesday, May 8, 1974
Grand Ballroom
Beginning at 9:30 a.m.

S. H. McDonnieal, Jr., Jackson
Chairman

Joe M. Ross, Jr., Vicksburg
Secretary

ECHOCARDIOGRAPHY
James L. Crosthwait, Jackson

THE SICK SINUS SYNDROME
Kenneth R. Bennett, Jackson

CURRENT CONCEPTS IN THE TREATMENT OF HYPERTENSION
Stanley B. Garbus, New Orleans

UPPER GASTROINTESTIAL BLEEDING
Marcel Patterson, Galveston

SCIENTIFIC PROGRAM



DR. GILLESPIE

Wednesday, May 8, 1974
Grand Ballroom
Beginning at 1:30 p.m.

William M. Gillespie, Jr., Meridian
Chairman

W. Boyce White, Laurel
Secretary

MANAGEMENT OF POSTOPERATIVE PAIN
Edward M. Sankary, Fort Worth

RECENT ADVANCES IN MYOCARDIAL INFARCTION
H. Davis Dear, Jr., Jackson

SCIENTIFIC PROGRAM



DR. GRIFFIN

Wednesday, May 8, 1974
Grand Ballroom
Beginning at 3:00 p.m.

Ruby B. Griffin, Calhoun City
Chairman

Steven L. Moore, Jackson
Secretary

ROLE OF PUBLIC HEALTH IN HYPERTENSION
Stewart L. Nunn, Memphis

SCIENTIFIC PROGRAM



Dr. Wiygul

Thursday, May 9, 1974
Grand Ballroom
Beginning at 9:30 a.m.

Frank M. Wiygul, Jr., Jackson
Chairman

Robert L. Abney, III, Jackson
Secretary

X-ray Clinic in Children's Heart Disease
David G. Watson, Jackson

Diagnosis and Management of Acute Lower Respiratory Tract Infections in Children
Floyd W. Denny, Chapel Hill

Unusual Respiratory Tract Infections in Children
Blair E. Batson, Jackson

SCIENTIFIC PROGRAM



Dr. Rogers

Thursday, May 9, 1974
Gulf Room A
Beginning at 9:30 a.m.

Lee H. Rogers, Tupelo
Chairman

James W. Rayner, Oxford
Secretary

Carcinoma of the Maxillary Sinus
Julius N. Hicks, Birmingham

Recent Advances in Ophthalmic Plastic Surgery: Part I
Alston Callahan, Birmingham

The Economics of an ENT Practice
Dr. Hicks

Recent Advances in Ophthalmic Plastic Surgery: Part II
Dr. Callahan

ALSTON CALLAHAN, M.D., Birmingham, Ala. Co-founder of Eye Foundation Hospital and President of the Eye Foundation; Consultant in Ophthalmic Plastic Surgery to the Surgeon General of the U. S. Army. Medical education, Tulane Medical School, 1933. Diplomate, American Board of Surgery.



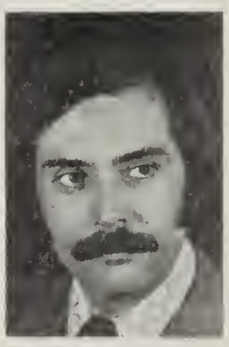
DR. CALLAHAN



DR. DENNY

FLOYD W. DENNY, JR., M.D., Chapel Hill, N. C. Professor and Chairman, Department of Pediatrics, University of North Carolina School of Medicine. Medical education, Vanderbilt University, 1946. Diplomate, American Board of Pediatrics.

STANLEY B. GARBUS, M.D., New Orleans, La. Assistant Professor of Medicine, Louisiana State University Medical Center; director, LSU Special Hypertension Clinic, Charity Hospital. Medical education, University of Geneva, Switzerland, 1962.



DR. GARBUS



DR. HALLENBECK

GEORGE A. HALLENBECK, M.D., Birmingham, Ala. Professor of Surgery and Physiology, University of Alabama Medical School. Medical education, Northwestern University Medical School, 1940. Diplomate, American Board of Surgery.

IRVING F. HAWKINS, M.D., Miami, Fla. Associate Professor of Radiology, University of Florida. Medical education, University of Maryland School of Medicine, Baltimore, 1962.



DR. HAWKINS



DR. HICKS

JULIUS N. HICKS, M.D., Birmingham, Ala. Professor, Division of Otolaryngology, Department of Surgery, University of Alabama Medical Center; Co-Chairman, Department of Otolaryngology, Veterans Administration Hospital. Medical education, Duke University, 1953. Diplomate, American Board of Surgery and American Board of Ophthalmology and Otolaryngology.

STEWART L. NUNN, M.D., Memphis, Tenn. Chief, Cardiovascular Section, V. A. Hospital, and Associate Professor of Medicine, University of Tennessee College of Medicine. Medical education, University of Tennessee College of Medicine, 1953. Diplomate, American Boards of Internal Medicine and Cardiovascular Disease.



DR. NUNN



DR. PATTERSON

MARCEL PATTERSON, M.D., Galveston, Tex. Professor of Medicine, University of Texas Medical Branch, Galveston. Medical education, Tulane University, 1943. Diplomate, American Board of Internal Medicine.

RUSSELL B. ROTH, M.D., Erie, Penn. President, American Medical Association. Private practice of urology and consulting urologist at V. A. Hospital, Erie. Medical education, Johns Hopkins University, 1939. Diplomate, American Board of Urology.



DR. ROTH



DR. SANKARY

EDWARD M. SANKARY, M.D., Fort Worth, Tex. Private practice of anesthesiology and chief, division of anesthesiology, Fort Worth Medical Center, Harris Hospital. Medical education, University of Texas Southwestern Medical School, 1962. Diplomate, American Board of Anesthesiology.

VISITING ESSAYISTS



DR. SAWYERS

JOHN L. SAWYERS, M.D., Nashville, Tenn. Professor of Surgery, Vanderbilt University. Medical education, Johns Hopkins University School of Medicine, 1949. Diplomate, American Boards of Surgery and Thoracic Surgery.



DR. WISER

WINFRED L. WISER, M.D., Memphis, Tenn. Professor and Deputy Chairman, Department of Obstetrics and Gynecology, University of Tennessee. Medical education, University of Tennessee College of Medicine, 1952. Diplomate, American Board of Obstetrics and Gynecology.

OLE MISS MEDICAL ALUMNI

University of Mississippi medical alumni, their ladies, and guests will meet on Monday, May 6, at the Sheraton-Biloxi. Alumni registration will be located adjacent to MSMA general registration in the second floor lobby and will be open at 10:00 a.m. where tickets for the evening party will be available. A general business meeting will be conducted at 4:00 p.m. on Monday in the Boston Room (main lobby arcade). The cocktail party will be held in the Top of Sheraton beginning at 7:00 p.m. and followed at 8:00 p.m. by the Seafood Jamboree dinner-dance. Dr. Ray L. Wesson of Biloxi is program planning committee chairman. Other committee members are Drs. Richard B. Ellison of Biloxi, David L. Clippinger of Gulfport, and Jare L. Barkley of Gulfport. Dr. John McRae of Laurel is alumni president. Further details and tickets may be obtained from Mr. Bill Price, medical alumni secretary, the Ole Miss Medical Alumni House, UMC campus, 2500 N. State Street, Jackson 39216.

TENNESSEE MEDICAL ALUMNI

Medical alumni of the University of Tennessee will enjoy an alumni banquet on Tuesday evening, May 7, in Gulf Rooms C and D at 6:00 p.m. Dr. Andrew K. Martinolich, Jr., of Bay St. Louis is president of the Mississippi chapter and arrangements are being made by Mr. H. Dale Almond, UT director of alumni affairs.

WOMAN'S AUXILIARY TO THE MISSISSIPPI STATE MEDICAL ASSOCIATION

51st Annual Session
The Sheraton-Biloxi
May 6-8, 1974

OFFICERS



MRS. PRESTON

MRS. W. H. PRESTON, JR.
Booneville, President

MRS. DAN REIKES
Hattiesburg, President-elect

MRS. W. A. BROWN, JR.
Mathiston, Secretary

MRS. HENRY H. WEBB
Jackson, Treasurer



MRS. REIKES

ANNUAL SESSION CHAIRMEN

Mrs. Jack A. Stokes
Pontotoc
General Chairman

Mrs. T. A. Baines
Jackson
Hospitality

Mrs. John M. Estess
Hollandale
Registration

Mrs. Lee Rogers
Tupelo
Luncheon

AUXILIARY

Sunday, May 5, 1974

2:00-6:00 p.m. Registration and Hospitality, Lobby, Lower Level

Monday, May 6, 1974

9:00 a.m. to 5:00 p.m. Registration

10:30 a.m. Finance Committee Meeting, Jackson Room

12:30 p.m. Luncheon, wives of past presidents of MSMA, Mary Mahoneys

2:00 p.m. Preconvention Meeting for Board of Directors, Jackson Room

4:30 p.m. Coffee honoring unit auxiliary presidents, Poolside

Tuesday, May 7, 1974

8:30 a.m. Continental Breakfast, Gulf Rooms C and D

8:30 a.m. Registration

9:30 a.m. General Session, Gulf Rooms C and D
Invocation
Welcome
Response
Introductions

Greetings

Arthur A. Derrick, Jr., M.D., Durant
President, MSMA
J. T. Davis, M.D., Corinth
President-elect, MSMA
Mrs. W. Nash Thompson, Stuart, Va.
President, Southern Medical Auxiliary

Memorial Service

Guest Speaker

Mrs. Williard C. Scrivner, Belleville, Ill.
President, Woman's Auxiliary to AMA

Roll Call
Minutes
Reports
Appointment of delegates to the Annual Meeting of Woman's Auxiliary to AMA
Business
Election of Officers
Installation of Officers

Mrs. W. Nash Thompson

Courtesy Resolutions
Adjournment

1:00 p.m. Luncheon, Top of the Sheraton
Invocation
Introduction of Guests

Guest Speaker

Mrs. Willard C. Scrivner

Presentation of Officers
AMA-ERF Awards

3:30 p.m. Postconvention Meeting for Board of Directors, Jackson Room

3:30 p.m. Special Film Presentation, Gulf Room B

Wednesday, May 8, 1974

8:30 a.m. Past Presidents' Breakfast, Jackson Room

10:00 a.m. Gourmet Fish Cookery Demonstration and Complimentary Lunch, Mrs. Bertha Fontaine, National Marine Fisheries Service

United Gas Company, Gulfport

10:00 a.m. Special Film Presentation, Gulf Room B

MISSISSIPPI DERMATOLOGICAL SOCIETY

The Mississippi Dermatological Society will hold its organizational meeting on Sunday, May 5, beginning at 10:30 a.m. in the Boston Room of the Sheraton-Biloxi. Officers are Dr. James M. Brock of McComb, president; Dr. Louis J. Wise of Jackson, president-elect; and Dr. Ronald R. Lubritz of Hattiesburg, secretary-treasurer.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

The Mississippi Society of Anesthesiologists will meet at the Sheraton-Biloxi in Gulf Room B, on Sunday, May 5, at 6:00 p.m. for a Dinner Program. Guest speaker will be Dr. David Little, president of the American Society of Anesthesiologists, who will talk on "Recertification of the Anesthesiologist." Society officers are Drs. Thomas J. Marland of Jackson, president; Carlos S. Patino of Jackson, president-elect; Katherine S. Aldridge of Hattiesburg, secretary and meeting chairman.

UROLOGY FOR THE PRIMARY PHYSICIAN

Sunday, May 5, 1974
Sheraton-Biloxi Hotel, Gulf Room C
Moderator: Dr. Lucas O. Platt

Beginning at 1:00 p.m.

Danger Signs of Stones—Dr. W. H. Merrell
Differential Diagnosis of Scrotal Masses—Dr. William Gates
Urinary Tract Infections in Children—Dr. James E. Keeton
Trauma to the Urinary Tract—Dr. Meredith Bradford
Sexual Disability in the Male—Dr. John E. Aldridge
Diagnosis and Management of Hematuria—Dr. Gerald Wessler
Panel Discussion: Urologic Problems in Family Practice
Drs. W. L. Weems, Merrell, Gates, Keeton, Bradford, Aldridge and Wessler

Cocktail Hour at 5:30 p.m. Gulf Room D (wives invited)

Time for discussion and questions has been set aside after each presentation. This course is approved for 4 hours elective credit from the Mississippi Academy of Family Practice. There will be no registration fee and the course is sponsored by the Mississippi Urological Society.

I wish to enroll in the Urology Course, May 5, at the Sheraton-Biloxi.

_____
Name and address

_____

_____

Return to: Division of Urology, University Medical Center, 2500 N. State Street, Jackson, MS 39216

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106th ANNUAL SESSION OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

May 6-9, 1974
at the
Sheraton-Biloxi
Biloxi, Miss.

Scientific Sections
Annual Meeting of the House of Delegates
Scientific and Technical Exhibits

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic)
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**)
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults — 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, "Rondomycin" (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q i d for a total of 5 4 grams
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of "Rondomycin" (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days
Children — 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: Rondomycin (methacycline HCl) 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

MISSISSIPPI NEUROSURGICAL SOCIETY

The Mississippi Neurosurgical Society will hold a scientific meeting with lectures and case reports on Monday, May 6, in Gulf Room C of the Sheraton-Biloxi. The society will sponsor a luncheon at noon on May 6 in the Boston Room. Officers of the society are Drs. Charles Neill of Jackson, president; O. J. Andy of Jackson, president-elect; and Lucien R. Hodges of Jackson, secretary.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Sheraton-Biloxi
May 5-6, 1974
GEORGE F. SMITH, Jackson, President
HOLLIS BURROW, Greenville, President-elect
ROLAND F. SAMSON, Jackson, Secretary
JOHN L. SMITH, Hattiesburg, Treasurer

Sunday, May 5, 1974
2:00 p.m. Business Meeting, Biloxi Room

Monday, May 6, 1974
9:00 a.m. Scientific Session, Biloxi Room
"Immunofluorescence in Diagnostic Anatomic Pathology"
Hines Bostwick, M.D.
Assistant Professor of Pathology
Director, Division of Pediatric Pathology
University Medical Center

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet for breakfast on Monday morning, May 6, in Gulf Room D at 7:00 a.m. Hosts are Drs. John B. Howell, Jr., of Canton, speaker, and Walter H. Simmons of Jackson, vice speaker. At this important meeting, committee members will be instructed in their duties and conduct of hearings to be held later in the day.

MISSISSIPPI ORTHOPAEDIC SOCIETY

The Mississippi Orthopaedic Society will hold a luncheon and program at 12:00 noon on Monday, May 6, 1974, in Gulf Room D at the Sheraton-Biloxi. Officers are Drs. William C. Sanders of Columbus, president; George W. Truett of Jackson, vice president; James O. Manning of Jackson, president-elect; L. Buford Yerger, Jr., of Jackson, secretary; and John G. Caden of Jackson, representative to AAOS.

MISSISSIPPI COMMISSION ON HOSPITAL CARE

The Mississippi Commission on Hospital Care will hold its monthly commission meeting on Monday, May 6, at 2:00 p.m. in the Biloxi Room at the Sheraton. Officers are Dr. H. J. Blakeney of Amory, president, Walter B. Crook, Jr., of Ruleville, vice president; Dr. A. V. Beacham of Magnolia, secretary; and Ernest C. Moss, Jr., Executive Director.

MSMA MEMBERSHIP-WIDE BREAKFAST

For the first time this year MSMA will host a breakfast for all members and their ladies on Tuesday morning, May 7, at 8:00 a.m. at the Top of the Sheraton.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century plus members at a special luncheon on Tuesday, May 7, in the Boston Room at 12:00 noon. Dr. James O. Gilmore of Oxford, chairman of the Board of Trustees, will preside. Mrs. Barbara Shelton, MSMA Membership Director, is club secretary.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Tuesday, May 7, in the Biloxi Room beginning at 12:00 noon. Officers of the society are Drs. George Ball of Jackson, president; Ira E. Gaddy, Jr., of Gulfport, president-elect; Kenneth P. Pittman of Jackson, secretary-treasurer; and Calvin T. Hull of Jackson, vice president.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The Sheraton-Biloxi
Tuesday, May 7, 1974
ALBERT L. MEENA, Jackson, President
RICHARD H. CLARK, JR., Hattiesburg, Secretary

12:00 noon Luncheon Meeting, Gulf Rooms A and B

2:00 p.m. Scientific Session, Gulf Rooms C and D
"Surgical Management of Postgastrectomy Syndrome"
John L. Sawyers, Nashville, Tenn.
"Surgical Management of Pancreatitis"
George A. Hallenbeck, Birmingham, Ala.
Topic to be announced
Irving F. Hawkins, Miami, Fla.
Case Reports
Business Meeting

A SHORT COURSE IN PRACTICAL TONOMETRY FOR NON-OPHTHALMOLOGISTS

The Mississippi EENT Association and the Mississippi Society for the Prevention of Blindness will again conduct a training course in indications and mechanics of tonometry including demonstrations and actual participation. The course will be offered at 4:00 p.m. on Tuesday, May 7, and Wednesday, May 8, in Gulf Room A.

FLYING PHYSICIANS ASSOCIATION, MISSISSIPPI CHAPTER

The Mississippi chapter of the Flying Physicians Association, Inc., will host a dinner at the Sheraton-Biloxi, in the Grand Ballroom, on Tuesday evening, May 7, beginning at 7:00 p.m. All FPA members and physicians interested in aviation are invited to attend. Dr. Max L. Pharr of Jackson is president and Dr. Lee H. Rogers of Tupelo is secretary-treasurer of the chapter.

TULANE MEDICAL ALUMNI

Medical graduates of the Tulane University will be feted at an informal cocktail alumni reception on Tuesday evening May 7, in Gulf Room B at 6:00 p.m. Ms. Ellen L. Smith, administrative assistant, is aiding in arrangements.

VANDERBILT MEDICAL ALUMNI

Vanderbilt medical alumni will gather in the Jackson Room at 5:30 p.m. on May 7 for a cocktail reception. Randolph Batson, M.D., Vice Chancellor for Medical Affairs Development, will be host.

MSMA PAST PRESIDENTS' BREAKFAST

Past presidents of the Mississippi State Medical Association will enjoy a breakfast meeting on Wednesday morning, May 8, in the Boston Room at 7:30 a.m. Dr. Charles R. Jenkins of Laurel is host.

AUXILIARY PAST PRESIDENTS' BREAKFAST

Past presidents of the Woman's Auxiliary to the Mississippi State Medical Association will enjoy a breakfast meeting on Wednesday morning, May 8, in the Jackson Room at 8:30 a.m. Mrs. Clarence Webb of Jackson is hostess.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will sponsor a luncheon meeting at 12:00 noon on Wednesday, May 8, at the Top of the Sheraton. Guest speaker will be Dr. W. R. Gillis, chairman of the Department of Family Practice at the University Medical Center in Jackson. Officers of the Mississippi academy are Dr. William B. Hunt of Grenada, president; Dr. Thomas J. Anderson of Laurel, president-elect; Dr. Richard T. Furr of Ocean Springs, vice president; and Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

A luncheon meeting of the Mississippi Society of Internal Medicine will be conducted on Wednesday, May 8, in Gulf Room B at 12:30 p.m. Officers of the society are Drs. David M. Owen of Hattiesburg, president and meeting chairman; Ellis M. Moffitt of Jackson, president-elect; and James C. Hays of Jackson, secretary.

ASSOCIATION PARTY

Members of the Mississippi State Medical Association, their ladies and guests will enjoy a cocktail party on Wednesday evening, May 8, outside by the pool at 7:00 p.m. There is no dinner or program, just good fellowship. Tickets will be available at general registration on the second floor lobby.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Thursday afternoon, May 9, at the Sheraton-Biloxi. All participating and administrative members are urged to attend.

MISSISSIPPI EENT ASSOCIATION

The Mississippi Eye, Ear, Nose and Throat Association will conduct a luncheon meeting on Thursday, May 9, in Gulf Room B at 12:00 noon. Officers of the association are Dr. Myron W. Lockey of Jackson, president; Dr. Patrick L. Pierce of Gulfport, vice president; and Dr. L. Ben McCarty, Jr., of Jackson, secretary-treasurer.

Handbook of the House of Delegates

Mississippi State Medical Association
106th Annual Session, Biloxi
May 6-9, 1974

SUPPLEMENTAL REPORT A
OF THE SECRETARY-TREASURER

Vacancies in Elected Offices. Effective May 9, 1974, there will occur 24 vacancies in elected offices in the association by reason of expiration of prescribed terms of service. In accordance with the By-Laws, the Nominating Committee will be asked to deliberate, consult with colleagues, and make nominations to the House of Delegates for consideration and voting to elect successors or to re-elect incumbents.

Eligibility. To be nominated for office in the association, a nominee must have been a member for two years, be in present good standing as a member, and must have attended two of the past three annual sessions. The present annual session may be counted as one of these two years.

Vacancies for Nomination. Following is the listing of vacancies which will occur during the 106th Annual Session as well as requirements for nominations and identity of incumbents:

President-elect

Nominate three, no two of whom may be from the same county, elect one.

Vice Presidents

Nominate three for the Northern Area, three for the Mid-State Area, and three for the Southern Area. Elect one for each area.

Delegate to AMA

Term Jan. 1, 1975-Dec. 31, 1976. Nominate two, elect one. Incumbent: Joseph B. Rogers, Oxford.

Alternate Delegate to AMA

Term Jan. 1, 1975-Dec. 31, 1976. Nominate two, elect one. Incumbent: Arthur E. Brown, Columbus.

Editor

Term 1974-76. Nominate two, elect one. Incumbent: W. Moncure Dabney, Crystal Springs.

HANDBOOK INFORMATION

The Speaker and Vice Speaker of the House of Delegates herewith present for the information of all members those reports and resolutions as have been received for publication in advance of the 106th Annual Session. It is the intent of this advance publication to inform the membership and to afford all concerned the opportunity to confer with delegates over any aspect of the reports and resolutions.

No report or resolution herein becomes official or a statement of policy until formally presented to the House of Delegates and acted upon at the annual session.

JOHN B. HOWELL, JR.
SPEAKER
WALTER H. SIMMONS
VICE SPEAKER

Associate Editor

Term 1974-76. Nominate two, elect one. Incumbent: George H. Martin, Vicksburg.

Board of Trustees, Districts 4, 5, and 6

Terms 1974-77. Nominate two for each district, elect one for each district. Incumbents: Paul B. Brumby, Lexington, District 4; Carl G. Evers, Jackson, District 5; and Guy T. Vise, Meridian, District 6.

Council on Budget and Finance

Term 1974-77. Nominate two, elect one, one vacancy. Incumbent: Gerald P. Gable, Hattiesburg.

Council on Constitution and By-Laws

Term 1974-77. Nominate two, elect one. Incumbent: Raymond S. Martin, Jr., Jackson (ineligible for reelection by reason of serving three consecutive terms).

Judicial Council, Districts 1, 2, and 3

Terms 1974-77. Nominate two for each district,

elect one for each district. Incumbents: John G. Egger, Drew, District 1; John R. Lovelace, Batesville, District 2; and Frank M. Davis, Corinth, District 3.

Council on Legislation, Districts 1, 2, and 3

Terms 1974-77. Nominate two for each district, elect one for each district. Incumbents: Walter H. Rose, Indianola, District 1; Thomas L. Ketchum, Ripley, District 2; and William H. Preston, Jr., Booneville, District 3.

Council on Medical Education

Term 1974-77. Nominate two, elect one. Incumbent: Carl G. Evers, Jackson.

Council on Medical Service, Districts 4, 5, and 6

Terms 1974-77. Nominate two for each district, elect one for each district. Incumbents: Edward Pennington, Ackerman, District 4; Tom H. Mitchell, Vicksburg, District 5; and William M. Gillespie, Jr., Meridian, District 6.

Mississippi State Board of Health

No vacancies occur in 1974.

Board of Trustees of Mental Institutions

Term 1974-1980. Five nominees to be submitted to the Governor. Nominate and elect five.

REPORT OF THE DELEGATES TO AMA

Your delegates to the American Medical Association, in conformity with custom and past practices, have limited their joint report to this House of Delegates to key policy actions at the annual and clinical conventions. Because of the comprehensive reporting in the *American Medical News* and *Journal AMA* of scientific and subsidiary activities, further reporting of these aspects of the AMA conventions would constitute needless duplication and repetition.

Dr. G. Swink Hicks of Natchez completed the second year of his two-year term Dec. 31, 1973, and he entered the first year of his next two-year term Jan. 1, 1974 (having been re-elected in May 1973). Dr. Joseph B. Rogers of Oxford completed the first year of his two year term on Dec. 31, 1973, and entered his second year Jan 1, 1974. Dr. Stanley A. Hill of Corinth completed the second year of his term as Alternate Delegate and began his first year of his second term Jan. 1, 1974 (having been re-elected in May 1973). Dr. Arthur E. Brown of Columbus entered his second year of his term as Alternate Delegate on Jan. 1, 1974.

This reporting covers the 122nd Annual Convention at New York City, June 24-28, 1973, and the 27th Clinical Convention at Anaheim, Calif., Dec. 1-5, 1973. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us.

New York Annual Convention. The AMA House of Delegates confronted with the largest business agenda in the association's history acted on a wide range of issues during the 122nd Annual Convention (June 24-28, 1973) which affect physicians in their relationships with government, medical schools and hospitals, and with the public.

The issues ranged from PSRO's and wage-price controls to institutional licensure and the need for more primary care physicians. Meeting for a total of 18 hours and 51 minutes, the House acted on 84 reports and 179 resolutions for a total of 263 items of business.

As might be expected, PSRO was one of the major subjects before the AMA House. Two reports from the Board of Trustees outlining successful AMA efforts in providing physician input into the drawing up of PSRO regulations by the government, and in other areas, were filed by the House. In addition, two resolutions bearing on PSRO's were adopted. One resolution, initiated by California and amended, reads as follows:

> *Resolved,* That the Secretary of Health, Education and Welfare be informed that the only organizations which can give qualified peer review for physicians' services to the patient, physician, government and taxpayer are those composed of practicing physicians, whether these are state or local groups; and be it further
>
> *Resolved,* That since many of these practicing physician groups are functioning successfully, with multiple approaches, as peer review organizations, the regulations be so written to authorize these existing peer groups to continue their review as PSRO's or as functioning units of PSRO's, thus partially alleviating the unnecessary and costly implementation of new agencies as PSRO's.

The second resolution adopted was a substitute in response to a number of resolutions introduced, ranging from those calling for the AMA to go on record in opposition to PSRO's, to one urging the association to seek repeal of the law. The substitute resolution, which conforms to PSRO policy approved by the House at the 1972 convention, reads:

Resolved, That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care.

Six resolutions were introduced protesting discrimination against physicians under the government's Economic Stabilization Program and the following substitute resolution was adopted by the House:

Resolved, That the American Medical Association continue to work by all lawful and practicable means to assure non-discriminatory treatment for physicians under present and future Economic Stabilization Programs.

In other actions affecting the relationship of physicians with government (and third parties), the House:

—Encouraged continued efforts to develop a uniform claim form for insurance claims.

—Supported the on-going efforts to educate physicians, private insurance plans and government agencies as to the advantages of adopting the 3rd edition of Current Procedural Terminology to identify and report services provided by physicians.

—And directed the Council on Medical Service to study the problems presented by "prospective admission" of hospital patients under Medicare and Medicaid, "retrospective denial" of benefits and report its findings and recommendations at the 1973 Clinical Meeting at Anaheim, California.

On the subject of institutional licensure, the House adopted a report of the Board which calls for the AMA to oppose the extension of institutional licensure in lieu of individual professional licensure to physicians and nurses. Testimony before the reference committee, including representatives of the nursing profession, was unanimously in support of opposition to institutional licensure.

Lengthy debate centered on a resolution from Illinois which protested unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs. Similar situations were reported in Arizona and South Dakota. A motion from the floor to refer the resolutions was defeated. After considerable discussion, delegates approved the following substitute resolution:

Resolved, That the American Medical Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper; and be it further

Resolved, That unilateral changes in medical staff bylaws by hospital boards of trustees is also improper; and be it further

Resolved, That the AMA suggest that the following preamble be included in all medical staff bylaws:

The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

The House approved a report of the Board of Trustees concerning physician distribution by specialties which has important implications for the medical profession and for the public. The report outlines the increase in number of medical schools, the increase in approved residencies and internships, and the increased number of allied health and continuing medical education programs. The report, as amended by the House, contained two important recommendations. They are:

The AMA should adopt immediately, publicize widely and promote vigorously a goal to have at least 50 per cent of all medical graduates enter residency training in the primary care specialties in the coming years.

The need for numbers and type of physicians should be monitored continuously and reassessed periodically in regular reports to the House of Delegates.

On the subject of physicians' unions, the House adopted a resolution presented by the New York delegation which reaffirms the tradition of the medical profession of not withholding medical services (withholding services is a practice of most unions), or performing any act interfering with public wel-

fare. The House also approved a Board of Trustee report which opposes unionism among self-employed physicians. The report also recognizes that physicians in employment situations need assistance and support, and encourages the Board of Trustees to maintain its interest and concern for these physicians. The report also affirms the no-withholding of services principle.

The House took several actions in regard to medical malpractice, including approval of a report from the Board of Trustees which outlines the proposed formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. The proposed commission was outlined by a planning committee consisting of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians and four specialty societies. An organizing meeting for the proposed commission will be held in Chicago in September.

After considerable discussion, the House voted a change in the AMA Constitution and Bylaws to provide a seat on the Council on Medical Services and the Council on Medical Education for a representative from the intern-resident members of the AMA.

A great deal of discussion also took place pertaining to the separation of the business and scientific meetings of the AMA. No final decision was made and the meeting will continue as combined meetings through 1976 as contracts have been formalized to that date.

In other action the House instructed the Council on Constitution and Bylaws to prepare for the 1973 clinical session (Anaheim, California, December 1973) a measure that will allow the House to vote on whether Trustees shall serve a maximum of two, three year terms. The present maximum is three, three year terms.

The House adopted several recommendations on the subjects of membership certification and dues. They were:

Physicians shall become members of the AMA upon certification by state medical societies rather than by AMA receipt of dues.

The delinquency date for remittance of AMA dues is changed from June 1 to April 30 of each year, and the requirement that members who have been dropped for non-payment of dues must pay one year's past dues is eliminated.

The criteria for exemption from AMA dues shall be consistent with exemption from state medical society dues, except that members reaching their 70th birthday may apply directly to the AMA for Active Dues Exempt Membership status.

Elimination of the requirement that AMA membership be limited to those physicians in military service whose tour of duty is two years or more. Younger physicians serving two years or less in the military or the U. S. Public Health Service will be eligible for AMA membership, and county and state medical societies are encouraged to adopt this procedure.

In other actions, the House:

—Adopted a substitute resolution recommending that the AMA urge the enforcement of strict penalties for the use of firearms in the commission of a crime.

—Tabled a resolution urging AMA support for the open sale of condoms to minors.

—Referred to the Council on Mental Health a resolution urging AMA support of a model penal code decriminalizing sexual behavior between consenting adults, and AMA support to end legal and employment discrimination against homosexuals. The council was instructed to report back at the 1973 clinical meeting.

—Affirmed the traditional favorable attitude of the medical profession toward pregnancy and motherhood, and encouraged the development of counselling programs that will offer constructive help to prospective mothers in coping with the stresses of pregnancy.

—Reaffirmed the AMA abortion policy which states "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice and the Medical Practice Act of his state. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment or personally held moral principles."

Officers elected were Russell B. Roth, Pennsylvania, installed as President; Malcolm C. Todd, California, President-elect; E. Bryce Robinson, Jr., Alabama, Vice President; Tom E. Nesbitt, Tennessee, Speaker of the House; William Y. Rial, Pennsylvania, Vice Speaker of the House; John H. Budd, Ohio, Richard E. Palmer, Virginia, James H. Sammons, Texas, and Kenneth C. Sawyer, Colorado, AMA Board of Trustees; George H. Mills, Hawaii, Judicial Council; John H. Burkhart, Tennessee,

Council on Constitution and Bylaws; J. Jerome Wildgen, Montana, Russell S. Fisher, Maryland, Louis Burgher, Minnesota (resident-intern member), Council on Medical Education; Hector W. Benoit, Jr., Missouri, Drew M. Peterson, Utah, Daniel Ostergaard, Minnesota (resident-intern member), Council on Medical Service.

(This report was prepared by G. Swink Hicks, M.D., of Natchez, Delegate to AMA.)

Anaheim Clinical Convention. The AMA House of Delegates elaborated on its policy position on Professional Standard Review Organizations (PSRO) during the 27th Clinical Convention of the AMA in Anaheim, Dec. 1-5. The House also addressed itself to problems arising from federal wage and price controls over health care providers as well as numerous other issues of concern to physicians and the public.

Meeting for a total of 14 hours and 36 minutes, the House acted on 67 reports and 81 resolutions for a total of 148 items of business, the biggest agenda for a Clinical Session in recent years.

Other issues considered ranged from malpractice problems to proposed improvements in health care delivery for migrant workers, and the method of election—and terms of service—of members of the Board of Trustees.

A total of 10 resolutions concerning the PSRO Law were introduced during the clinical session, more than for any other item of business. Reference Committee A, which began its hearings of PSRO shortly before noon Monday, Dec. 3, heard more than four hours of testimony from physicians expressing various shades of opinion, and did not complete its preliminary report until the early morning hours of Tuesday.

After more than two hours of additional discussion on PSRO's on Wednesday, the House of Delegates adopted Report EE of the Board of Trustees, as amended, in lieu of the various resolutions which had been submitted. The report summarized PSRO developments to date and outlined previous AMA policy in confronting the PSRO issue. The House adopted the following amendment to Report EE of the Board of Trustees:

"The AMA affirms the following principles:

"1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

"2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

"3. That the association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

"4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality, and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public. The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our longstanding policy and opposition to this legislation prior to passage."

In adopting the above amendment, the House made special note that the last paragraph of Report EE remains the same. The last paragraph reads:

"The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations."

Four resolutions and two reports were introduced dealing with discriminatory Phase IV Wage-Price Controls on health care providers and institutions. The House approved a Board of Trustees report announcing AMA support for the American Hospital Association in its battle against proposed controls over acute care hospitals. Delegates also adopted a substitute resolution which directed the AMA to continue "as a matter of high priority" to seek relief for physicians from wage-price controls "using all available administrative resources," and that "the Board of Trustees be authorized to institute appropriate legal action when so advised by legal counsel."

HOUSE OF DELEGATES / Continued

In opening-day remarks which drew a standing ovation from the House, Dr. Russell B. Roth, president of the AMA, discussed some of the complex issues surrounding peer review and Professional Standards Review Organizations.

The only way to effectively assure high quality care is through professional peer review, Dr. Roth said, because "ultimately, excellence of medical care is determined by the competence, the motivation, and the integrity of the physician who provides it."

The problem with most lay-initiated peer review proposals is that they are based on the mistaken premise that good health care can be provided through improved delivery systems or institutionalization, according to Dr. Roth.

"Since the delivery of most medical care takes place outside the hospital, and because the quality of care is not something that can be measured in dollars of cost or hours of time, peer review standards such as those proposed under PSRO will be difficult to establish," he said.

"Regardless of how one may derive standards and norms, the matter of judging conformity and of evaluating exceptions and divergencies is a peer professional problem.

"We should reflect that a medical school is regarded as good because it is adjudged to be so by physician graduates, physician faculty members, and physician contemporaries."

Dr. Roth added that more attention will be paid to evidence that physicians are keeping abreast of medical progress and are maintaining their medical competence, but he said that "This too will undoubtedly be accomplished by peer evaluation."

Dr. Roth did not take sides on the PSRO question, but spoke for "the good and useful things that we may do to identify high quality of care, and of the immense difficulties in doing this well."

But Dr. Roth concluded that "If solutions were to come easily it would not be a challenge—and challenge it is. In the meantime the nation will be well advised to put its confidence in the competence, the integrity, and the motivation of the medical profession."

Because of the wide-ranging nature of the actions taken by the House of Delegates, and for the sake of clarity, this summary report will be divided into four subject areas with appropriate subheadings: Physicians and Hospitals and Medical Schools; Physicians and the Public; Association and Internal Matters of the House; and Miscellaneous.

Physicians and Hospitals and Medical Schools

Preadmission Certification—The House considered two resolutions dealing with proposed government regulations that would impose a hospital preadmission certification program for patients under Medicare. A resolution adopted by the House directed the AMA to take all steps necessary to prevent enactment of regulations mandating hospital preadmission certification and to determine whether such regulations would be in violation of Medicare law.

Another resolution which would have the AMA request the Secretary of HEW not to allow the publishing of preadmission certifications in the *Federal Register,* and also would have the AMA seek Congressional support for this position, was referred to the Board of Trustees and the Council on Legislation. (Note: Subsequent to the meeting, the Secretary officially published proposed preadmission certification requirements in the *Federal Register* and the AMA officially stated its intent to seek legal redress if the proposed regulations were made final.)

Funding Medical Education—A report from the Board of Trustees, which outlines continuing AMA efforts to secure balanced funding for medical education and research, was adopted by the Delegates. The report describes several studies of the cost of medical education and its relation to the cost of medical care that are presently underway, and points out that the Council on Medical Education is closely monitoring the results of such studies with a view toward future actions.

Quality Assurance Program—After considerable discussion, the House adopted a resolution that offers the American Hospital Association the cooperation of the AMA in deliberations on the AHA's Quality Assurance Program. The AMA will seek the elimination of features it considers undesirable. A final resolve puts the AMA on record as disapproving the QAP in its present form.

Intern and Resident Matching Program—The House adopted a report of the Board of Trustees which recommends that the present National Intern and Resident Matching Program remain in effect. Two resolutions introduced at the 1973 Annual Session had proposed that the National Matching Program abandon its "all or nothing" policy. Testimony before the reference committee which considered the matter indicated students endorsed the Board report. The committee added that further study of the matching program is being conducted by the Liaison Committee on Graduate Medical Education and the Coordinating Council on Medical Education.

Health of Migrant Workers—Development of a possible nationwide health insurance program for migrant workers is one of several proposals contained in a Council on Medical Service report approved by the House.

The report states that such an insurance program is possible and adds that there is a need for migrant health advocates who would be paid for their services rather than be volunteers.

Under action taken by the House, the Council on Medical Service is instructed to develop a version of such an insurance program.

Confidentiality of Records—The House adopted a report of the Council on Medical Service that describes efforts to find practical solutions to problems related to maintaining the confidentiality of patient records. The House further instructed the council to prepare model legislation to preserve confidentiality as a guide to possible state legislation. Also adopted was a resolution that puts the AMA on record in opposition to violation of the confidentiality of patient records by government agencies under all circumstances.

Alcoholism—Under a resolution adopted by the House, the medical treatment and admission of alcoholics would be improved. The resolution recommends to the American Hospital Association that it urge member-hospitals to liberalize admission policies for alcoholics where necessary, urges physicians to abstain from using the names of other pathological conditions in lieu of alcoholism, urges the Joint Commission on Accreditation of Hospitals to implement the intent of the resolution as one of its requirements for approval, and urges insurance companies and prepayment plans to remove unrealistic coverage limitations for treatment of alcoholics.

Health Care of the American Indian—The House adopted and referred to the Board of Trustees for further action a report by the Council on Medical Service and its Committee on Health Care of the Poor regarding proposed improvements in the Indian Health Service. The report summarized the total picture of Indian health, and contained recommendations on how to improve the Indian Health Service programs of the federal government.

National Blood Program—The concept of the proposed AMA plan to implement the government's National Blood Policy by organizing blood banks and transfusion facilities within a national system that retains regional and local responsibilities and authority was endorsed by the House.

Definition of Death—Because of complex legal ramifications, the House adopted a policy position that at present the statutory definition of death is not desirable or necessary, that state medical associations urge their legislators to postpone enactment of definition of death statutes. The House also affirmed the following statement: "Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria.

The Dying Patient—The House adopted the following statement to serve as a guideline for physicians confronted with ethical problems related to euthanasia (mercy killing) and death with dignity:

> "The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> "The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

ASSOCIATION AND INTERNAL MATTERS OF THE HOUSE

Terms of Service of Trustees—Proposed amendments to the by-laws that would have limited members of the Board of Trustees to a maximum of two full terms of three years each were not adopted by the House. The action retains the present provision allowing trustees to serve three full terms of three years each.

Method of Electing Trustees—In a related action, the Delegates approved two other resolutions that will allow candidates for the American Medical Association Board of Trustees to run at large rather than for designated "slot" positions as is presently done. One of the resolutions adopted outlines the methods to be followed in at-large election of trustees, while the other deals with any necessary changes in the by-laws.

Specialty Representation in House—The House took several actions related to direct representation of national medical specialty societies in the House of Delegates. The House adopted a report of the Council on Constitution and Bylaws calling for a thorough study of the proposal including an open hearing at the 1974 Annual Meeting. Two resolutions, both calling for the rejection of direct repre-

(Turn to page 192)



The President Speaking

"A Curious Atony"

ARTHUR A. DERRICK, JR., M.D.
Durant, Mississippi

AFTER ALMOST a year now of searching my cluttered brain for subjects on which I might find something of interest with which to fill this space, I have come up with perhaps as far-fetched a simile as one could imagine. I intend to liken our medical careers to pregnancy!

I suppose what suggested this wild comparison is my intention to induce a multipara today who is two weeks past her EDC.

Somewhere along the line each of us became impregnated with the determination to become a physician. During the long prenatal period of training we were nourished with a seemingly unending supply of knowledge funneled down to us, filtered in placental fashion by whichever school we happened to attend, until we were fair bursting with new-found knowledge and skill—our count was high, almost plethoric, we were at term, ready to loose all this know-how on unsuspecting patients. But then a curious atony occurred to most of us. In the ceaseless round of patient care many of us cloistered ourselves in an antiseptic esoteric world apart, completely satisfied that we were doing all we should or could. Oh, for a metaphorical Pitocin drip to expel us, with a good APGAR score, of course, into the factual world of politics, in which our profession now finds itself embroiled. A deep episiotomy may be required for some, namely, me! From our position of respect in the community, revealed repeatedly in the polls, we are in a peculiarly apt posture to exert a much-needed influence on today's political actions.

After bouncing around the state visiting the component societies (preaching my "involvement" sermon) and having just returned from the AMPC workshop in Washington, during which the word "apathy" was bandied about over and over, the speakers, from within and without the profession, stressed the importance of rousing us out of our apathy toward the political and legislative scene, which steadily more deeply affects the practice of medicine.

Our lack of interest astounds the political-scene watchers, who insist that we must become, to use the most overworked word of the year, "involved," if we are to effectively influence the sequelae of the politician's actions on us as a profession. Admittedly, for many of us who have studiously avoided any contact with, much less involvement in, anything that smacked of "politics," this furtive entry into a milieu so foreign to our prior convictions of being above the "sordid" political scene will be a lot like one's first visit to a bordello —wondering how we got there, hoping no one saw us, and doubting our effectiveness as to the task in hand! We must remember that they are not all statesmen, just as we are not all quacks. We just cannot afford to allow our profession's political position to go by default, accepting, grudgingly, of course, whatever happens to come out of the hopper. The vehicle is there, namely, PAC, which we all should join, support and bring on down to the local level. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

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APRIL 1974

EDITORIALS

CHIP, Health Security or Medicredit?

With the recent introduction of the Nixon Administration's Comprehensive Health Insurance Program (CHIP) all parties on the national scene now have legislative proposals before Congress to provide an extensive health care program for the American people. The great health care debate will soon begin. But unlike the debate preceding enactment of Medicare and Medicaid in 1965 when the issue was "shall there be a national health care program?" this time the issue appears to be "which national health care program is the best?"

President Nixon says any health care program should build upon the strengths of the health care system the American people presently have and not destroy it. The American Medical Association agrees and supports its own Health Care Insurance Act (Medicredit).

Senator Edward M. Kennedy calls his Health Security Act (HSA) the most comprehensive program available and states that the health care system needs the reorganization that enactment of HSA would provide. Senator Abraham Ribicoff claims that the most pressing need while Congress debates other health care programs is for a catastrophic illness program such as provided by the Long-Ribicoff Catastrophic Insurance and Medical Assistance Act. The American Hospital Association, the U. S. Chamber of Commerce and the insurance industry have also introduced proposals.

If a national health care program is enacted within the next two years—and many think it will be—it will probably be a program somewhere between the Kennedy and Nixon-AMA proposals. Senator Kennedy's proposal would drastically reorganize the health care system or perhaps as he would like to put it—create a health care system to replace the present non-system. The Health Security Act, which has the support of most of organized labor as well as the National Council of Senior Citizens, would essentially remove all benefits and co-payment restrictions on the Medicare program and expand it to everyone. A National Commission would be created to "set standards for quality health care" and physicians would be "encouraged" to practice in a group environment on a capitation or salary basis.

President Nixon's Comprehensive Health Insurance Program would build on present employer-employee group insurance programs. The present Medicare program would be continued with expanded benefits and Medicaid would be replaced with a federally-assisted insurance program for the poor. Benefits would consist of unlimited hospital and physician care, preventive care for children up to age 13, 100 days of nursing home care, and mental health and other services subject to a family deductible of $450 and 25 per cent co-payment. Catastrophic benefits would be provided after personal expenditures of $1,500 under the employer-employee plan and $750 under the Medicare program. The AMA Medicredit proposal though similar to CHIP is not as extensive in benefits and regulatory requirement. CHIP, Health Security or Medicredit? The great debate will soon begin!

CHARLES L. MATHEWS
Executive Secretary

Voting Index May Amaze You

Within the next few weeks each MSMA member will receive a "health voting index" on their Senator(s) and Representative(s) in the Mississippi Legislature. Some of the data thus far has been amazing. It completely negates some longstanding views about some members of the Mississippi Legislature. These views were based for the most part on what the legislator said rather than what he actually did.

The index was recommended by the Council on Legislation at the 1973 Annual Session and approved by the House of Delegates. It will annually identify the health bills before the Mississippi Legislature, beginning in 1972, which physicians in Mississippi through their MSMA House of Delegates, Board of Trustees, and Council on Legislation supported or opposed. It will show the vote of each MSMA member's Senator(s) and Representative(s) on these bills and then give the legislator's health voting percentage based on his support or opposition to bills supported or opposed by physicians in Mississippi.

In its report to the 1973 House of Delegates recommending the "health voting index" the Council on Legislation noted the growing importance of state legislation because of the "move government back to the states policies" of the Nixon Administration. This importance continues to grow as illustrated by recent proposals and actions to establish health regulatory requirements administered by state and private agencies and to place new health regulatory functions within the states such as the Medicare-Medicaid certificate of need requirements for institutional construction.

For good health and good government reasons, the Council on Legislation is encouraging each Mississippi physician to be more cognizant of his state legislator and what he stands for when he has to stand for election in 1975. The "health voting index" will be a useful resource in this regard. Watch for it. You may be amazed!

CHARLES L. MATHEWS
Executive Secretary

Medico-Legal Briefs

EXPANDED JURISDICTION UPHELD IN SUIT AGAINST DRUG MANUFACTURER

A suit in a federal court in Mississippi by a Kansas woman against a drug manufacturer incorporated in Delaware should not have been dismissed, a federal appellate court ruled. The drug company, a manufacturer of the pill, was not so involved in its Mississippi operation as to give that state's courts jurisdiction preempting federal jurisdiction.

Alleging that the manufacturer of her birth control pills had inadequately tested the drug and that she had suffered a serious and debilitating stroke from using the pill, the Kansas resident brought an action in the federal trial court in Mississippi. The action was brought in Mississippi to take advantage of that state's six-year statute of limitations. Jurisdiction was based on a Mississippi statute that allowed the woman to attach a two and one-half million dollar debt owed to the drug manufacturer by three Mississippi drug wholesalers.

Saying that Mississippi could not assert jurisdiction over the manufacturer, the trial court dismissed the case. An appeal was taken, and the federal appellate court reversed the lower court. Noting an earlier Mississippi Supreme Court decision holding that jurisdiction could be obtained by attachment in



"Being cheerful is fine, Mrs. Jones, but can't you think of something to say besides 'you come back'!"

a case involving nearly identical facts, the appellate court said it was bound by that decision.

After concluding that the attachment statute was applicable, the court launched into a review of a series of U. S. Supreme Court decisions on the constitutionality of obtaining jurisdiction by attachment. The conclusion reached was that there was no constitutional prohibition against Mississippi taking jurisdiction over the drug manufacturer. The intangible debt owed to the manufacturer by the Mississippi wholesalers was sufficient contract with the state that no hardship would be imposed on the manufacturer to defend the suit in Mississippi. The dismissal of the action was reversed.—Steele v. G. D. Searle and Company, 483 F.2d 339 (C.A.5, Aug. 14, 1973)

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

April 8-12, 1974

PULMONARY MEDICINE INTENSIVE COURSE

University Medical Center, Jackson

April 8-12, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinators:

Joe R. Norman, M.D., professor of medicine, Christ-

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

Mar. 25-Apr. 7

Alopecia in Diagnosis, with Norman Orentreich, M.D. Clinical Associate Professor of Dermatology and Syphilology, New York University School of Medicine, New York City.

The Medical Management of Metastatic Breast Cancer, with Justin J. Stein, M.D., Professor of Radiology and President of the American Cancer Society, University of California, Los Angeles.

The Differential Diagnosis of Systemic Lupus Erythematosus, with Naomi F. Rothfield, M.D., Professor of Medicine and Chief, Arthritis Division at the University of Connecticut School of Medicine, Farmington.

April 8-April 21

Long-Term Management of Systemic Lupus Erythematosus, with Naomi F. Rothfield, M.D., Professor of Medicine and Chief, Arthritis Division at the University of Connecticut School of Medicine, Farmington.

Digitalis: Friend or Foe?, with James E. Doherty, M.D., Professor of Cardiology, University of Arkansas, and Director of Cardiology, Veterans Administration Hospital, Little Rock.

The Treatment of Bronchial Asthma, with Frank Perlman, M.D., Clinical Professor of Medicine, Practicing Allergist, University of Oregon School of Medicine, Portland.

April 22-May 5

Herpes Simplex: Clues for Clinical Diagnosis, with Richard C. Gibbs, M.D., Associate Professor of Clinical Dermatology, New York University Medical Center, New York.

The Treatment of Acne, with Paul Lazar, M.D., Associate Professor of Dermatology, Northwestern University School of Medicine, Chicago.

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change)

mas Seal Professor of Pulmonary Disease, and director of the Pulmonary Division, The University of Mississippi School of Medicine

A. W. Conerly, M.D., instructor in medicine and director of respiratory therapy, The University of Mississippi School of Medicine

An integrative approach to the more common pulmonary problems will be the focus of this course. Formal lectures will cover respiratory failure, asthma, ventilators, tuberculosis and fungal disease. Daily rounds will emphasize physical diagnosis, pathophysiology and diagnostic techniques. The annual Boswell Lecture will be presented on Friday.

April 22-26, 1974

RADIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
April 22-26, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Robert D. Sloan, M.D., professor and chairman of the Department of Radiology, The University of Mississippi School of Medicine

The course will include practical observations of radiologic procedures in the diagnostic, therapeutic, and isotope areas and sessions on equipment, techniques, artefacts, and radiation safety. Participants will play an active role in numerous diagnostic conferences on radiographic interpretation.

May 13-17, 1974

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson
May 13-17, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

John D. Bower, M.D., associate professor of medicine and director of the Artificial Kidney Unit, The University of Mississippi School of Medicine.

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease. The management of acute kidney failure and control of reversible features of chronic kidney disease will be presented in depth. The management of pyleonephritis, fluid and electrolyte problems, and acid base balance will be covered and the participants will become familiar with hemodialysis in clinical nephrology.

All the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

April 19, 1974

RENAL SEMINAR

University Medical Center, Jackson
April 19, 1974

Sponsored by the University of Mississippi School of Medicine Postgraduate Education Committee and the Departments of Medicine, Surgery (Urology), and Pediatrics.

Coordinator:

John D. Bower, M.D., associate professor of medicine and director of the Artificial Kidney Unit, the University of Mississippi School of Medicine.

W. Lamar Weems, M.D., associate professor of surgery and chief of the Division of Urology, The University of Mississippi School of Medicine.

This seminar brings together three outstanding physicians for a one-day discussion of calcium—bones and stones. Lectures will take up the fundamentals of calcium and phosphorus metabolism, renal osteodystrophy, hypercalciuria of immobilization, calcium absorption from the gut, and bone and stone disease. Guest speakers include nephrologist Dr. Jack Coburn of Wadsworth VA Hospital in Los Angeles, urologist Dr. Donald Griffith of Baylor College of Medicine, and pediatric nephrologist Dr. Donald Fraser of the Hospital for Sick Children in Toronto, Ontario.

FUTURE CALENDAR

April 8-12
PULMONARY MEDICINE INTENSIVE COURSE

April 19
RENAL SEMINAR

April 22-26
RADIOLOGY INTENSIVE COURSE

May 6-9
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 13-17
NEPHROLOGY INTENSIVE COURSE

May 15-16
CONTROVERSIES IN CARDIOLOGY, TRI-STATE HEART ASSOCIATION, BILOXI

Book Reviews

Comments in Sports Medicine. Edited by Timothy T. Craig, Ph.D., et al. 230 pages with illustrations. Chicago, Ill.: Department of Health Education, AMA, 1973. $5.00.

The American Medical Association Committee on the Medical Aspects of Sports and the National Federation of States High School Federation have recognized the need for fundamental information in sports medicine. This book gives an excellent, simple coverage of health problems among our athletes. The interest of the American people in sports has been overwhelming in the last 10 years. Our coaches and athletes as well as the physicians, themselves, have not been properly motivated in the prevention and care of the injuries which occur as a by-product of sports. Each year across the playgrounds and athletic fields of America, problems are arising which are handled in an uneducated manner.

Comments on Sports Medicine covers the problems encountered in a very clear way with understandable terminology and is well documented and well written. The common terms in athletic injuries are compared to the scientific terms as well as the treatment. A particular chapter on the importance of proper equipment should be beneficial, particularly to the athletic departments of the schools. An important discussion is carried out on the use of drugs, particularly those that are being misused and abused today, namely, the amphetamines, the androgenic-anabolic steroids, alcohol, smoking, etc. The increasing popularity of the professional athletes and the problems with drugs in this group have made this chapter particularly important. A discussion is held regarding the female athlete and the particular problems which she faces. I can never remember reading the points brought up in this chapter and I think they are well done and will be important to the coaches handling the female athletes as well as the girls themselves. The instructions and information regarding nutrition in athletes should be of invaluable assistance to the coaching staff in instructing teams in proper diet and general health care.

In summary, this is an excellent addition to the physician's library as well as that of the athletic department and coaches. It should improve their knowledge. I would certainly recommend it for anyone involved in athletics, either as a participant, coach, or physician.

Richard J. Field, Jr., M.D.
Centreville, Miss.

Allergy Management in Clinical Practice. By Louis Tuft, M.D. 426 pages with illustrations. St. Louis, Missouri: The C. V. Mosby Company, 1973. $29.75.

For approximately 40 years it would appear that Dr. Louis Tuft delegated unto himself the matter of trying to keep the medical profession informed on the subject of allergy. His first publication in the 1930's was evidently intended for the novice; his second publication in 1949, which was comprehensive and complete, was to aid the general practitioner; this present book, it seems to me, could best be used by the physician doing allergic work. This present work was evidently written by one with extensive knowledge in the field of allergy and immunology. In fact, he apparently becomes so enthused over his subject at times that he used the terms one would expect an allergist to use—not the words of one explaining a subject to some unknowledgeable medical man.

Publications in the allergic field have apparently been pretty well covered by Dr. Louis Tuft as well as others. This particular book does not cover many subjects not adequately covered in other such books. It does not, to my mind, however, adequately cover the advances made in the field of immunology during the last decade. In former years, we could give repeated antigen injections to a patient and eventually build his immunity to the point that he could tolerate that specific product. We had no idea of why or how this was accomplished; all we knew then was that it was accomplished. With the knowledge acquired in the field of immunoglobulins in the past decade or more, we can now tell how these antibodies were increased and why.

Dr. Tuft discusses briefly the experimental use of prostoglandins. He also discusses disodium chromoglycate (cromolyn sodium) explaining that this helps asthma by inhibiting the release of histamine. While

this product has not improved all cases, it has a very definite favorable effect in many cases. It is probably worthy of trial in all cases, though desensitization should not be excluded.

Otherwise this publication, to me, seems to be a repetition of the advice and suggestions made previously. I do not find anything else that is new, or that was not being done previously.

Application of the manner of treating allergic patients 20 or 30 years ago gave these patients pretty good results in general. I seriously doubt that Dr. Tuft has given us much more knowledge of how to handle patients or get better results in *Allergy Management in Allergic Practice* than was known and practiced 30 years ago.

GEORGE W. OWEN, M.D.
Jackson, Miss.

LETTERS

SIRS: In the past years several clusters of Reye's Syndrome have been reported in close temporal relationship to outbreaks of influenza B. Outbreaks of influenza have been reported from over 20 states this winter including Mississippi. Influenza B virus has been isolated from patients in a number of states. Influenza B is also suspected in Mississippi because primarily school-age children in rural areas have been affected. This is similar to epidemiologic patterns seen in influenza B outbreaks in previous years. Specimens from representative cases in Mississippi have been sent to the CDC, Atlanta, for virologic studies.

Reye's Syndrome is an acute childhood encephalopathy with fatty degeneration of the viscera. The etiology of the syndrome is unknown. The clinical picture has been characterized as biphasic. The initial prodromal phase is generally associated with an antecedent upper respiratory viral illness. The second phase is characterized by an acute encephalopathy and coma and in a high percentage of cases, death. The Center for Disease Control, Atlanta, is very interested in receiving reports of any cases of suspected Reye's Syndrome that occur in the state. If suspected cases occur, please call 354-6650.

DANIEL J. SEXTON, M.D.
Medical Epidemiologist
State Board of Health

1. Glick, T. H., Libosky, W. H. and Levitt, L. P.: Reye's Syndrome: An Epidemiologic Approach. Pediatrics 46:371, 1970.
2. Morbidity and Mortality Weekly Report, Vol. 23, No. 6, February 9, 1974, p. 55.

SIRS: The Bureau of Disease Control is currently participating in a national collaborative study of meningococcal disease. The purpose of the study is to determine the risk to family contacts of cases of meningococcal meningitis and/or meningococcemia. Estimates of secondary attack rates in family members during epidemics of meningococcal disease have ranged from 1.3 to 4.8 per cent.[1-3] However, the secondary attack rates following sporadic cases of meningococcal disease have not been adequately determined.

By collecting information concerning a large number of cases and their household contacts, this study is designed to estimate the secondary attack rate for meningococcal disease occurring in the United States during January-March, 1974.

We request that any physician or local health facility aware of a case of meningococcal disease in the next two months send the meningococcal isolate to the Mississippi Public Health Laboratory, Jackson 39205, and promptly notify Dr. Daniel J. Sexton (601-354-6650 or 601-956-6934).

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

REFERENCES

1. Lee, W. W.: Epidemic Meningitis in Indianapolis, 1929-1930. J. Prev. Med. 5:203-209, 1931.
2. Gordon, J. E.: Septicemic Meningococcus Meningitis in *Infections of the Central Nervous System*. Ed.: Straus, I., Williams and Wilkins Co., 1932, pp. 453-476.
3. Pizzi, M.: A Severe Epidemic of Meningococcus Meningitis in Chile, 1941-1942. A. M. J. Public Health 24:231-238, 1944.

DEATHS

AYCOCK, ALLIE M., Rose Hill. M.D., University of Tennessee College of Medicine, 1935; interned Ford Sanders Hospital, Knoxville, Tenn., one year; died Dec. 31, 1973, age 64.

BARBER, HOMER D., Biloxi. M.D., Louisiana State University School of Medicine, New Orleans, La., 1936; interned Charity Hospital, New Orleans, La., one year; resident in internal medicine, U. S. Marine

Hospital, Galveston, Tex., 1936-37; internal medicine residency, V. A. Hospital, New Orleans, La., 1946-48; died Dec. 6, 1973, age 62.

THOMPSON, JAMES GRANT, Jackson. M.D., University of Tennessee School of Medicine, Memphis, Tenn., 1931; interned U. S. Marine Hospital in New Orleans while a member of the U. S. Public Health Service; preceptorship, New York Skin and Cancer Unit of Columbia University, 1935; dermatology residency, Columbia University, New York City; former president, vice president and secretary-treasurer of the Southeastern Dermatological Association; presented the Wisdom Award of Honor in January 1974; chairman of the building committee of the Mississippi State Medical Association; Past-President of MSMA, 1951-52; chairman of Department of Dermatology, University of Mississippi School of Medicine; died Feb. 23, 1974, age 71.

NEW MEMBERS

DIPLACIDO, JOHN, Houston. Born Utica, N. Y., Mar. 31, 1940; M.D., University of Alabama Medical College, Birmingham, Ala., 1967; interned, same, one year; NIH student fellowship in Endocrinology, University of Alabama, 1965-66; ob-gyn residency, same, 1968-71; elected by Northeast Mississippi Medical Society.

HUDSON, HAROLD KEETON, Tupelo. Born Memphis, Tenn.; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned, same, one year; otolaryngology residency, same, 1967-71; elected by Northeast Mississippi Medical Society.

Intestinal Absorption Symposium Planned

An international symposium on Intestinal Absorption and Malabsorption will be held May 28-30 at the University of Kentucky Medical Center in Lexington.

There is a registration fee of $150. For further information write Dr. Ronald D. Hamilton, director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

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Woman's Auxiliary to the Mississippi State Medical Association

50

"An Accounting . . ."

In this memorable year when others have waited in line for gas, streaked across the campus and fallen at the watergate, it is only appropriate that we make an accounting of what your Woman's Auxiliary to MSMA has "been up to"!

This year WA/MSMA marked the beginning of her fifty-first year. To give permanent emphasis to our Golden Anniversary we are printing our Fifty Year *history,* unveiling a lovely commemorative *quilt* and compiling beautiful books of medical *biography* all over the state. At convention we will honor past state *presidents* and recognize Mississippi *artists* in medicine.

Mississippi Woman's Auxiliary supported the WA/AMA program with particular attention to *health education* and services for *venereal disease, drug abuse, child abuse, postnatal child care* and *nutrition.*

We have made great strides in understanding the needs and the intricacies of *medical legislation.*

We have continued sponsorship of *nurses loans* and recruitment programs for *medical and allied health personnel.*

WA/MSMA *membership* and contributions to *medical education* via AMA-ERF have increased.

We were born on the deck of a steamboat 51 years ago. The Good Ship WA/MSMA is still afloat and geared for new vision and greater energy. Since ours is a continuing program, we expect the best yet to be!

Early in the year we renewed our dedication as doctors' wives by pledging to put our *husband's welfare first.* We hope that it has made a difference. . . .

Jane Preston
(Mrs. William H. Preston, Jr.)
President, WA/MSMA

PERSONALS

O. J. Andy of Jackson and UMC presented papers at the Southern Neurosurgical Society meeting in Key Biscayne and at the Society of Neurological Surgeons meeting in Los Angeles.

M. L. Arrington of Prentiss was named Man of the Year at the annual banquet of the Chamber of Commerce in Prentiss.

Duff Austin, William Billups and Thomas Greer of Meridian are serving as physician advisors to the Meridian Chapter of the Medical Assistants Society.

Robert E. Blount, Clarence Mast and Calvin Hull of Jackson and UMC participated in an infectious disease seminar in Bermuda recently.

J. E. Boggess and David E. Ulmer of Columbus announce the new address of their Columbus Eye Clinic at 425 Hospital Drive, Suite no. 8.

Richard Boronow of Jackson and UMC met with the fellowship committee of the American Cancer Society in New York in February.

Alfred W. Brann, Jr., of Jackson and UMC spoke on pediatric neurology at Johns Hopkins University in Baltimore.

Carlos Chavez of Jackson and UMC was inducted into the American College of Cardiology in New York in February.

Dawson B. Conerly of Hattiesburg was crowned King Zeus XXXIV at the Golden Anniversary celebration of the Mystic Krewe of Zeus held at the Hattiesburg Country Club.

Samuel I. Feurst of Vicksburg participated in a national telephone conference on "Anxiety and Its Treatment."

Thomas E. Goyer, formerly of Memphis, has joined the staff of the Tishomingo County Hospital in Iuka for the practice of surgery.

Stanley Hartness of Kosciusko was named Attala County's Outstanding Citizen for 1973 by the Kosciusko Lions Club at the annual banquet.

The Field Clinic of Centreville announces the association of Frank Hava, a psychiatrist, the first Thursday in each month.

Glyn Roy Hilbun of Moss Point was crowned King of Joy XXXVII at the Jackson County Coronation Ball sponsored by the Young Men's Business Club of Moss Point.

Michael Jabaley of Jackson and UMC met with the NIH Cancer Control Program committee on grants review in Bethesda, Md.

William Jacquith of Whitfield was honored by the Disabled American Veterans for his "humanitarian" efforts at their mid-winter conference in Jackson.

Samuel Johnson of Jackson and UMC attended the annual meeting of the Mississippi Association of Children with Learning Disability in Oxford.

Wesley W. Lake of Gulfport received the Special Recognition Award at the Rotary Awards Banquet held at the Pass Christian Yacht Club. Dr. Lake was presented a plaque commemorating him for his services to the community and his work with the heart association.

T. D. Lampton of Jackson, coordinator for the Mississippi Regional Medical Program, attended a SE/RMP self-assessment committee meeting in Atlanta.

John E. Lindley of Meridian has been elected to serve for two years as Chief of Staff of Jeff Anderson Memorial Hospital. Other officers elected are: William L. Thornton, vice Chief of Staff, and George E. Howell, secretary. Chiefs of services are: Elbert M. Jones, ob-gyn; George L. Arrington, Jr., surgery; Oscar W. Irby, medicine; and John D. McEachin, pediatrics.

William A. Long, Jr., of Jackson was featured speaker at the Northside YMCA Parent-Education Seminar at Chastain Jr. High Auditorium in Jackson. Topic for the seminar was "Present Day Problems of Adolescents and the Parents' Role in These Problems."

Benjamin P. Monaco announces the relocation of his office to Doctors' Plaza Eye Clinic, 4211 Hospital Road in Pascagoula.

J. G. Nassar of Jackson announces the expansion of his office for treatment of diseases and surgery of the eyes at 611 Medical Arts Building.

Joe Norman of Jackson and UMC attended a postgraduate course on current concepts in diagnosing

pulmonary disease sponsored by the California Thoracic Society in San Francisco.

JIM G. NORRIS, II, announces the opening of his practice of neurology in offices at the Coastal Medical Center, P. O. Box 4080, Biloxi.

JOHN F. RUSSELL of Gulfport received the 1974 AMA Physician's Recognition Award for completing postgraduate education requirements.

ETHELYN SMITH and JOHN POWELL of Senatobia were honored with Citizenship Awards at the 19th annual Chamber of Commerce banquet.

AKIO SUZUKI of Jackson and UMC participated in a program on coronary artery medicine and surgery concepts and controversies at the Texas Heart Institute in Houston by presenting a paper on surgery for impending myocardial infarction.

JAMES T. THOMPSON of Moss Point was elected Councilor from Mississippi at the annual meeting of the Southern Medical Association in San Antonio.

Z. L. WEATHERFORD of Fulton was honored at a birthday party in February. Three of Dr. Weatherford's classmates from the U.T. Medical School class of 1914 attended the party.

W. LAMAR WEEMS of Jackson and UMC attended a urologic forum in Las Vegas in February.

Clinical EEG Course Is Planned

The ninth annual continuation course in "Current Practice of Clinical Electroencephalography," sponsored by the American Electroencephalographic Society, will be held in Seattle, Washington, on July 22-24, 1974.

The course is approved by the AMA Council on Medical Education. Further information may be obtained from the course director, Dr. Donald W. Klass, Mayo Clinic, Rochester, Minn. 55901.

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Introducing: the Dean of the University of Mississippi School of Medicine

The new dean of the medical school and Vice Chancellor for Health Affairs of the University of Mississippi, when asked his goal for UMC, put it this way: to serve the health education needs of the citizens of Mississippi.

Dr. Norman C. Nelson is interested in the welfare of this institution and in its ability to discharge its mission. He adds, "We work for the people of Mississippi."

The 43-year-old surgeon came to the University Medical Center in July 1973 from his position as Dean of the LSU School of Medicine in New Orleans.

In a special interview for the JOURNAL MSMA, Dr. Nelson said the School of Medicine has its largest class enrolled to date with 122 freshmen medical students. There are a total of 432 medical students on the campus now, he added.

He believes 122 will remain the highest number of freshmen the school will be able to enroll the next few years because of lack of facilities and faculty. The physical plant of the medical center has had to undergo extensive renovation to accommodate the present number. In order to provide more classroom and laboratory space, the school now offers summer clerkships in pathology, medicine, ob-gyn and psychiatry.

The vice chancellor is not an advocate of the three year medical school programs. He feels the summer recess, even though most medical students find work in medically-related fields, provides a necessary change of pace and time for the students to mature. He believes in the four calendar year approach while recognizing that some students can do it quicker.

Providing more primary care physicians for the state is one of the greatest needs. He said, "There are now four family practice residents at UMC and much interest has been displayed by the students in this new residency program."

In the future Dr. Nelson sees the possibility of adjusting the number of training positions in overcrowded specialties. He feels that people in medicine should be involved in structuring this.

The medical center overall shows a definite period of growth, he pointed out. There are 1,098 students enrolled in all segments of health education for the





(Note: This is the first in a series of interviews with Mississippi's health leaders. Next up will be Dr. Alton B. Cobb, State Health Officer.)

first quarter as compared to 976 the previous year, representing over a 10 per cent increase.

Many diverse training programs are now in operation which is in contrast to the traditional role of a school of medicine and a school of nursing. All schools have grown except the graduate program which has managed to remain the same size despite federal cutbacks in research programs. Dr. Nelson attributes this to intra-institutional support of the graduate program which currently has 83 graduate students enrolled in masters and Ph.D. programs.

Dr. Nelson said the new school of dentistry is in the process of developing its curriculum and is preparing for a site visit for accreditation in fall of 1974. The newly appointed dean, Dr. Wallace V. Mann, is established on campus and the goal is to enroll a class of 25 dental students in September.

Continuing education for medical professionals has high priority for the new dean. He disclosed that they are seeking a fulltime person to staff this program and a long range goal is a building for postgraduate education with an auditorium and classrooms.

Dr. Nelson noted that the medical center has branched out its training programs and now uses the V. A. Hospital in Jackson extensively and also Mississippi Baptist Hospital, Hinds General, St. Dominic and North Mississippi Medical Center at Tupelo.

He said that satellite centers have been established for some programs including newborn intensive care, but that this type of activity has to have a positive commitment on the part of the legislature (appropriations) and the community involved.

When asked the biggest problem immediately facing the medical center, he replied lack of space. There are too few offices that were too small to begin with and now many have been divided to accommodate more faculty and staff. There are four trailers on campus for ongoing programs and six more have been ordered.

Dr. Nelson said the University Hospital is now operating at over 85 per cent occupancy rate and there is a real need for more facilities for ambulatory and acute services.

Other pressing needs are a student union, recreational facilities for students and more parking space.

In regard to the medical center's image as a charity institution, he believes that UMC has a mandate to "provide care for those less-fortunate folk who don't have the resources for private physicians."

When asked how he feels about his new position, he said, "We've got a fine institution; it's responsive to all segments and groups."

SBH Receives Nutrition Grant

A $700,000 federal grant has been awarded to the Mississippi State Board of Health by the U. S. Department of Agriculture's Food and Nutrition Service.

According to Dr. Alton B. Cobb, Mississippi State Health Officer, the six-month grant represents the initial funding for the 18-month program.

The federal money will be utilized in funding three supplemental food programs for women, infants, and children in Issaquena-Sharkey Counties, Warren County, and the Hinds-Rankin Maternal and Infant Care Project.

"The program is designed to assist those people who have been determined by a physician to be nutritionally at risk, such as pregnant women, infants, or other children up to age four," said Dr. Cobb.

The Issaquena and Sharkey County project has been designated a special study project which involves doing a battery of medical tests and evaluations at periodic intervals on a sample of patients, according to Dr. Frank M. Wiygul, Jr., director of the Bureau of Maternal and Infant Care at the State Board of Health.

According to Dr. Wiygul, the special project will attempt to assess the effects of the supplemental foods on the patient's health as well as outcome of pregnancy.

He also noted that each patient involved in the three projects must be medically certified to have need of the supplemental foods.

The basis for the program, according to Dr. Wiygul, is to demonstrate that specific nutrients and micro-nutrients (vitamins and minerals) will improve the health of pregnant women and their infants and young children and that they will improve the outcome of pregnancy as shown by increased birth weight, less illness, better development and a drop in infant mortality.

Foods on the approved list and to be served are milk, cheese, eggs, cereals, and fruit juices for adults and young children; for infants, an iron fortified formula plus juices and cereal will be provided.

MSMA Presents Check to SAMA Officers



Dr. Arthur A. Derrick, Jr., of Durant, MSMA president, is shown presenting a check for $250 to help defray expenses to the annual Student American Medical Association Convention, Mar. 1-3, in Dallas to state chapter officers, Alan J. Orkin of Jackson, president, and Hughes Milam of Tupelo, vice president.

Miss. Heart Association Sponsors Biloxi Meet

Fourteen speakers from medical centers across the United States will be featured at the 1974 Tri-State Scientific Session on heart disease to be held May 15-17 at the Broadwater Beach Hotel in Biloxi.

Sponsored by the Mississippi, Arkansas and Louisiana Heart Associations and the American Heart Association Council on Clinical Cardiology, the seminar for physicians will have as its theme "Controversies in Cardiology."

Speakers for the three-day event will be: Dr. Alberto Benchimol, Good Samaritan Hospital, Phoenix; Dr. G. S. Berenson, LSU Medical Center; Dr. Howard B. Burchell, University of Minnesota; Dr. John J. Collins, Jr., Peter Bent Brigham Hospital, Boston; Dr. M. Leonard Dreifus, Hahnemann Medical College and Hospital, Philadelphia; Dr. Herman K. Hellerstein, Case Western Reserve University, Cleveland; Dr. Richard S. Ross, The Johns Hopkins University; Dr. Borys Surawicz, University of Kentucky; Dr. James E. Doherty, VA-UAMC Hospitals, Little Rock; Dr. Quinton H. Dickerson, St. Dominic Hospital, Jackson; Dr. Harper Hellems, University of Mississippi Medical Center; Dr. Edgar Hull, LSU School of Medicine; Dr. Albert L. Hyman, Tulane School of Medicine; and Dr. Akio Suzuki, University of Mississippi Medical Center.

The program has been accredited by The Council on Medical Education of the American Medical Association for 12 hours of credit toward the AMA Physician's Recognition Award and by the American Academy of Family Physicians for 12 elective hours.

The seminar planning committee is headed by Dr. W. H. Rosenblatt of Jackson. Serving with him are: Dr. Malcolm B. Pearce, Little Rock; Dr. James W. Wilson, Jr., Shreveport; Dr. John H. Phillips, New Orleans; Dr. Wesley W. Lake, Pass Christian; Dr. Kenneth Bennett, Jackson; and Dr. Harry J. Schmidt, Biloxi.

For registration forms and additional information, contact: Mrs. Pat H. Roundtree, Program Director, Mississippi Heart Association, 4830 East McWillie Circle, P. O. Box 16063, Jackson 39206.

State Family Physicians Serve as Preceptors

Fifty family physicians from 35 Mississippi cities will take University Medical Center senior medical students into their hometown practices for three-week periods beginning in July.

Dr. Wilfred Gillis, chairman of the Department of Family Medicine, who sponsors the program, said the preceptors give students a realistic look at family medicine practice and the role of the family physician in his community.

Physicians who'll serve as preceptors this summer attended an orientation workshop at the University Medical Center last month.

Students who participated in the preceptorship program in 1973 said that it played an important part in their decisions to go into family medicine careers, according to Dr. Gillis.

Students' activities in the local communities include operating room assignment, reviewing x-rays with the radiologists, reading EKG's at the hospitals, library research and visits to the county health departments.

MSMA Members Speak to Medical Assistants

A symposium entitled "Broadening Horizons" was sponsored by the Mississippi Society of the American Association of Medical Assistants in February at Primos Northgate Convention Hall in Jackson.

Speaking during the morning session were Dr. W. L. Jacquith, director of Mississippi State Hospital at Whitfield, who discussed "Drug Abuse in Mississippi," and Dr. Jose M. Montalvo, associate professor of pediatrics at the University Medical Center, who talked about "Pediatric Endocrinology."

On the afternoon agenda were Dr. James D. Hardy, professor and chairman of surgery at UMC, who spoke on "Current Status of Cardiac Surgery"; Dr. Edward M. Lowicki of Jackson who discussed "Cancer—A New Day Dawning"; and Dr. John D. Bower, director of the Artificial Kidney Unit at the Medical Center, who spoke on "Kidneys for Those Who Can't."

Mrs. Helen Donohoo of Gulfport, president of AAMA, MS, and Miss Jane Clowe of Jackson, president of the Central chapter, conducted the meeting.

"The Mississippi Society of Medical Assistants," stated Mrs. Carol Smith, chairman of the state education committee, "realizes that in providing symposiums such as this one, we increase the knowledge and professionalism of our members and fellow workers and stimulate a feeling of fellowship and cooperation among the members of the society. In better educating the medical assistants of Mississippi, we can, in turn, better serve both the patients and physicians."

Medical Center Graduates Pediatric Nurse Associates

Mississippi's first pediatric nurse associates will soon begin aiding physicians in the routine care of newborns and children.

The two registered nurses, Ms. Cheryl Jean Laughlin of Jackson and Ms. Wilma Jean Dixon of Clarksdale, received their pediatric nurse associate certificates March 1 in ceremonies at the University Medical Center.



The first graduates under the University Medical Center's pediatric nurse associate program help Dr. Peter Boelens, assistant professor of pediatrics, center, check a newborn baby at the UMC nursery. The graduates are Ms. Cheryl Jean Laughlin of Jackson, left, and Ms. Wilma Jean Dixon of Clarksdale, right. The new nurse associates will aid physicians in routine infant care, freeing them to treat cases requiring more specialized skills.

Pediatricians, nurses and specialists in paramedical areas at the University Medical Center serve as faculty for the program offered in the School of Nursing with medical school Department of Pediatrics cooperation.

A pediatric nurse associate student, who must have at least two years experience as a registered nurse, can work in a variety of settings upon graduation—public health, community health center, with private physicians, or in outpatient and hospital facilities. A second six-month component is planned for adult health nurse associates.

Human Sexuality Program Set for June

The Institute for Sex Research at Indiana University in Bloomington will hold its 1974 summer program in Human Sexuality June 16-27.

The summer program includes lecture courses, forums on sociosexual issues, sex counseling symposium, and an attitude-reassessment program. There is a registration fee of $285 and registration ends May 17.

For more information write Institute for Sex Research, 416 Morrison Hall, Indiana University, Bloomington, Ind. 47401.

Charlie Pride Headlines 1974 Miss. Art Festival

Mississippians will welcome home Charlie Pride —headliner for the eleventh annual Mississippi Arts Festival—on Saturday, May 4, in the coliseum. Doc Severensen, accompanied by his two touring groups —Today's Children and The Now Generation Brass, will be featured in Friday night's coliseum show. Performances by the Jackson Symphony Orchestra and classical singers will round out the coliseum programs both nights.

In the Municipal Auditorium the Jackson Ballet Guild will offer an evening of ballet on Tuesday, April 30, featuring Patricia McBride and Jean Pierre Bonnefous. Keith Burger, talented mime, will be on the fairgrounds throughout Festival Week, April 30-May 5.

The Sesame Street cast will join the Jackson Symphony Orchestra's popular youth concerts this year. The Mississippi Art Association will feature a one-man showing by Feliciano Bejar of Mexico City in addition to their collegiate and competitive exhibits.

An exciting part of this year's festival will be the greatly expanded and diversified seminars offered.

The Old Capitol Museum Exhibits and Seminars will house exhibits of works by Edward Marshall Boehm and Bill Dunlap. The lectures and exhibits of Mr. Dunlap, professor of art at Appalachian State University, stress Literal Images from Literary Sources. Mrs. Edward Marshall Boehm, who has had a special porcelain camellia designed for Carol Waller, will lecture on Wednesday, May 1, in the House Chamber. Both exhibits will be open to the public all week.

By popular demand, there will be a repeat of the slide-illustrated seminar on designing and creating antique reproductions by David Pruett of Natchez. Mr. Pruett will be one of hundreds of talented craftsmen who will join artisans in action. Budding authors will want to attend the Literary Seminar by Shelby Foote and the Poetry Seminar by Turner Cassidy.

Cooking seminars will stress pickles, seafood, and pastries under the guidance of three of the South's most talented cooks. These seminars will be conducted in the War Memorial Building Auditorium and shown on closed circuit TV.

Completing the seminars will be the Historical Pilgrimage which will feature four historical private homes never before opened to the public.

To complement this stellar national and international entertainment, the Mississippi Arts Festival will also offer a showcase for talented Mississippians. New Stage will be open nightly during MAF week performing their popular *Gershwin Review; Cool in the Furnace* will be presented for the younger set on the Fairgrounds.

Artisians in Action, the hit of past festivals, will return with more than 125 artisans creating objects of beauty and usefulness.

Top notch musicians, vocalists, actors and artists from throughout the state will exhibit their skills in attractions along the Midway, with concerts and coffeehouse entertainment featured nightly. Artists of every age and talent will be included in seven major exhibitions. The new statewide Song Competition will choose a song about Mississippi for the festival's theme; the Literary Competition will also be on the scene once more.

Entertainment will be offered for young people of all ages. A new Youth Pavilion will cater to the junior high age group. The children's pavilion which allows youngsters to participate will be supplemented by plays, concerts, and storytelling.

Order forms for tickets appear in newspapers throughout the state. The purchase of a ticket to any of the three performances will entitle the purchaser to enter the Fairgrounds free throughout the week.

The festival is sponsored by Mississippi Arts Festival, Inc., which was established in 1969. Serving as chairman of the 1974 production committee is Mrs. Ed Peters. Assisting are Mrs. J. T. Noblin, co-chairman; Mrs. John Anderson, treasurer; Mrs. John Crawford, secretary, and Mrs. Stuart Liles, promotion.



Shown are six medical wives who are working with the 1974 Mississippi Arts Festival which will be held April 30 through May 5. From left are Mesdames Richard Blount, James Gordon, Clarence Webb, James Keeton, Kenneth Reed and Ancil Tipton, all of Jackson.

1974 Miss. MECO Program Announces Plans

The plans for MECO 1974 in Mississippi are underway. MECO, Medical Education-Community Orientation, is in its 4th year of *very* successful operation. MECO is an educational program for preclinical and clinical medical students based in a community hospital or group practice clinic. The project provides students with an exposure to the community practice of medicine as a supplement and alternative to the disease oriented and highly specialized medicine taught in medical schools. MECO enables both practicing physicians and other health professionals to become involved in the education of future physicians. The students are placed in these positions in the summer for a 10 week period.

The long range goals of MECO are: (1) to affect the future distribution of health manpower in the United States and to help physician shortage areas attract future physicians, (2) to affect future patterns of health care delivery, and (3) to provide an opportunity for health science students to participate in the development of their own educational programs, as a means of establishing a true continuum of education extending the medical school years.

During the summer assignment the students are introduced to the community and to the cultural, economic, political and environmental determinants of health in that community. MECO strives to make the student aware of the organization and operation of health care institutions as related to delivery of health care in the community. The program also will enable students to evaluate their career goals and better plan their medical education as related to specific community needs in health care. And most importantly, the student is then enabled to understand the concept of patient-oriented health care.

Participating hospitals and clinics will be required to provide a weekly stipend ($85) for each student

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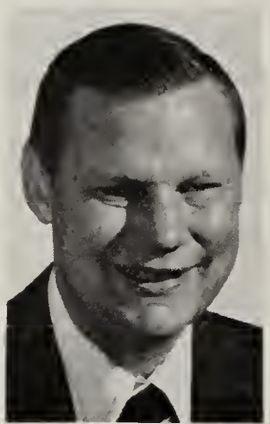
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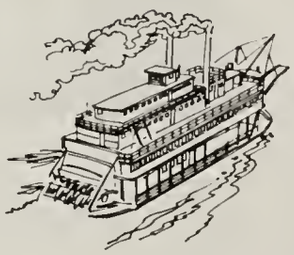

Will Gargis


Bert Godwin


Jim Gordon


Dennis Spencer


Terry Whitney



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These men bring you ...

plus room and board or additional stipend for such expenses where not provided. The physician or hospital director is free to organize the program for his particular student as he desires.

Presently the MECO program in Mississippi is one of the most active in the United States. All of the students who have participated have been greatly appreciative of their opportunity to get into community medicine.

Any physicians interested in the MECO program may contact either the Mississippi Hospital Association or Susan Buttross, SAMA, University Medical Center, Jackson 39216.

Delta MH/MR Center Sponsors Drug Seminar

The Delta Mental Health/Mental Retardation Program (Bolivar, Washington, Sharkey and Issaquena counties) will sponsor a week-long seminar at Greenville April 22-26, according to Dr. Gilbert S. Macvaugh, Jr., executive director for the region. Two instructors from the National Institute of Mental Health will lead the "Social Seminar on Drugs, Education and Society" from 9 a.m. to 5 p.m. each of the five days.

The seminar will be limited to 40 participants, and applications should be filed with Miss Betty Fullilove, M.S.W., Delta MH/MR Program, P. O. Box 599, Greenville, Miss. 38701.

The seminar will be designed to give educators, parents, police, medical personnel and others the "opportunity to examine the human, social and cultural issues surrounding the problem of drug abuse," according to Dr. Macvaugh.

He said the basic function of the seminar is "to help people grow in terms of understanding the behavior and motivations of themselves and others."

Participants will use a guidelines booklet and an instruction text containing facts of the pharmacology, effects and history of drugs, and 15 films will be shown. In addition, a role-playing exercise will allow participants to experience the attitudes and behavior of "persons quite different from themselves."

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Jackson Clinic Treats Muscular Dystrophy

The Muscular Dystrophy Association of America, Inc. sponsors a Mississippi clinic every second and fourth Friday afternoon each month, between 12:00 noon and 4:00 p.m. at the North Clinic, University Hospital, 2500 N. State Street in Jackson.

The clinic is headed by a board-certified neurologist with consultants in genetic counseling and orthopaedic surgery, according to Robin Selcer, MDAA Patient Services Coordinator.

Services provided by MDAA include: (1) each patient is seen in the clinic for an initial visit and one follow-up visit per year (additional visits at physician's request); (2) MDAA will pay for all necessary orthopaedic appliances when prescribed by a physician, necessary repairs of this equipment, three days hospitalization for examination, testing and initial evaluation (if physician deems this necessary); (3) physical therapy (once a week, evaluation every three months); (4) flu shots if needed; and (5) carrier tests. Payment for medication is not provided by MDAA.

MDAA will provide a Medical Release Form which is to be completed by both the patient and his/her physician and returned to the MDAA office, 365 West Northside Drive, Suite 5-C, Jackson 39206.

Also needed are referral from family or attending physician and copies (if available) of all prior medical reports relative to possible muscle disease.

Emergency Services Assn. Plans Meet

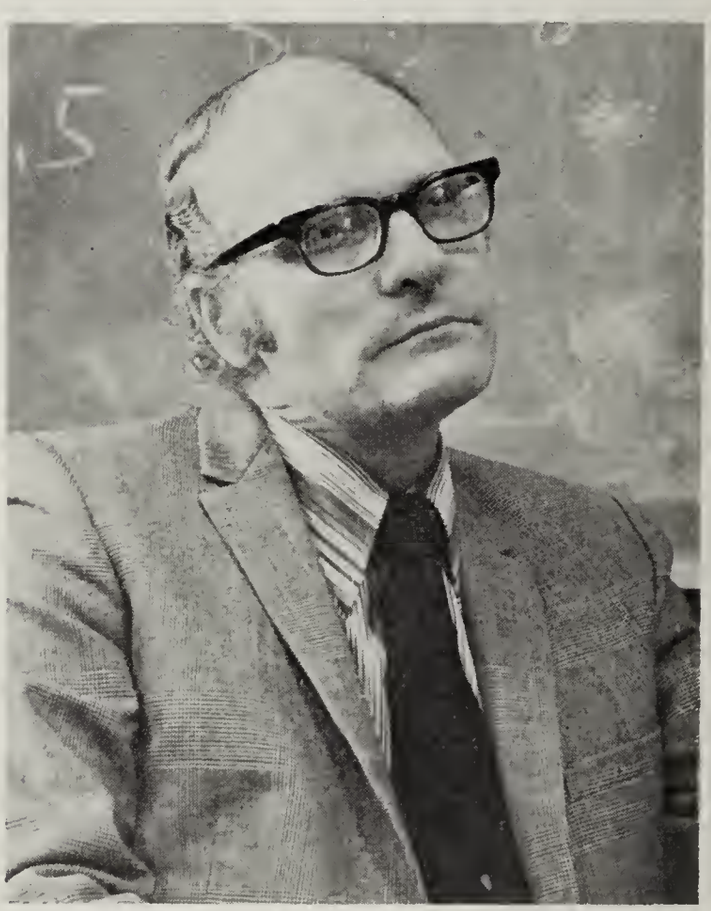
The University Association for Emergency Medical Services will hold its fourth annual meeting at the Sheraton-Dallas Hotel in Dallas May 28-June 1.

Papers will be presented on emergency medicine as a specialty, emergency department design and organization, cardiac telemetry, and residency programs in emergency medicine.

There will be a registration fee of $60 which includes all luncheons, the reception, dinner, and bus transportation.

For reservations and information write University Association for Emergency Medical Services, P. O. Box 1241, East Lansing, Mich. 48823.

Noted Cancer Researcher Speaks at UMC



"So many different varieties of cancer exist, it's doubtful that cures will be discovered as soon as has been predicted." That's the opinion of Dr. Barth Hoogstraten, director of the University of Kansas Clinical Cancer Program, who spoke at the University Medical Center last month. The renowned cancer researcher is professor of medicine at the University of Kansas Medical Center and was formerly chief of hematology at Greenpoint Hospital in New York. He spoke to UMC faculty and students during a weekly assembly program.

Medical Students Choose Family Practice

A survey of 1974 graduating medical students by the American Academy of Family Physicians shows that (1) more medical students than ever before are choosing family practice as their specialty, and (2) that the demand for first-year spaces in family practice residencies exceeds the number of spaces available by almost two to one.

The purpose of the study, conducted by the academy's Education Division, was to determine what deficit—if any—existed in first-year spaces before

the National Intern and Resident Matching Program (NIRMP) results are released.

One hundred and sixty of the 191 approved residencies have responded so far. As of Feb. 4, these training units reported 2,014 graduates seeking first-year spaces. Estimated spaces available stand at about 1,170, leaving a deficit of 844 graduates desiring first-year spaces.

Dr. Robert Graham, assistant director of the AAFP Education Division, said residency directors have indicated to him that if enough financial and faculty support could be obtained, extra spaces might be created to absorb at least some of this deficit.

Dr. Graham also estimated that approved family practice residency training programs will probably reach the 230 mark by Jan. 1, 1975. This, he says, coupled with program expansion, hopefully will create enough second-year spaces to allow some of the unsuccessful 1974 applicants to transfer from interim training of another type to family practice residency training in 1975.

Dr. Graham anticipated that family practice programs will graduate more than 350 family physicians this year. This increase, and future estimates, indicate healthy progress toward the academy's announced goal of having at least 25 per cent of the nation's medical school graduates enter family practice.

Digestive Diseases Courses Scheduled for May

Five societies representing physicians and surgeons in the gastroenterological sciences will join together in a week-long series of meetings and study sessions in San Francisco, May 19-25, 1974.

Under the umbrella theme of Digestive Disease Week, the meetings will include two postgraduate courses (the American Gastroenterological Association course on Peptic Ulcer Disease May 19-20 and the American Society for Gastrointestinal Endoscopy course on Gastrointestinal Endoscopy May 20-21) plus scientific meetings and lectures May 21-25.

The Society for Surgery of the Alimentary Tract will hold scientific sessions on May 21. On May 22, registrants will attend sessions sponsored by the Society for Surgery of the Alimentary Tract, the American Society for Gastrointestinal Endoscopy and the Gastroenterology Research Group.

For information, write Charles B. Slack, 6900 Grove Road, Thorofare, N. J. 08086.

College of Allergists Sets Annual Congress

More than 80 scientific sessions, one-fourth of them featuring leading European clinicians and researchers in allergy, will highlight the 30th Annual Congress of the American College of Allergists in Paris April 15-22.

The meeting, which marks the opening of the new $100 million Paris Convention Center Complex, has already attracted nearly 1,000 registrants.

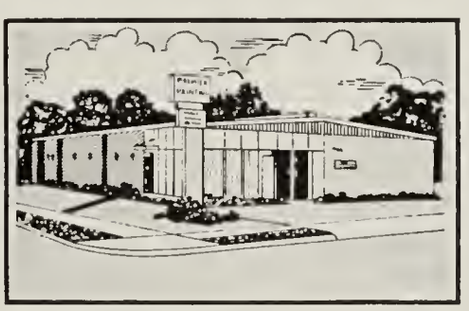
The Congress keynoter will be Robert Good, M.D., Ph.D., president and director of the Sloan-Kettering Institute for Cancer Research, New York.

Travel packages, including registration fee, regularly scheduled Air France flights from any of seven U. S. "gateway" cities and seven days in Paris, are available from $640 to $840 per physician, depending on the gateway city. Rates for accompanying spouses are $200 less.

For information about registration and travel—including a selection of four post-Congress tours—Contact Jerry Hassler, Albany Four Star Travel, Box U, Brookline, Mass. 02146, or phone (617) 232-6726.

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sentation by the specialty societies, were referred to the Council on Constitution for consideration in its study.

Professional Liability—A report of the Board of Trustees, which summarizes the development of the new Medical Liability Commission formed by the AMA, AHA, and several national medical specialty organizations, was endorsed by the House. Delegates further directed that the Board of Trustees "grant the highest priority for financial and organizational support" for the commission.

The Board of Trustees will request that the commission give some priority to basic research in the field of medical liability and will urge the present Secretary of HEW to consult and cooperate with the commission.

The action also puts the House on record as urging all delegates, state and local medical associations, and other medical organizations to support the new commission, and to submit to it any appropriate comments, suggestions, or ideas for easing malpractice problems.

Renal Dialysis—Acting on a report from the Council on Medical Service and on several resolutions, the House adopted a strong policy position on renal dialysis and transplant procedures under Medicare. The report and resolutions objected to the "interim regulations" issued by the federal government in respect to renal dialysis and transplant under Medicare, since the regulations establish what is tantamount to a maximum fee schedule on a national basis for professional services, and in effect dictate on a national scale the method by which certain kinds of medical care are rendered.

Under actions taken by the House, the AMA will strongly protest—and seek to rescind—the interim regulations; request that the federal government return to existing systems of determining medical necessity for treatment and setting fees; and—with consultation from concerned medical specialty societies—work with the government in redrawing the interim regulations.

In miscellaneous actions, the House:

—Referred to the Council on Medical Service a resolution urging the AMA to oppose wide differences in fees for medical services performed by equally qualified physicians who practice in different geographic areas of a state. . . .

—Adopted a report recommending that summaries of court decisions on informed consent be made available to physicians on request rather than the compilation of model guidelines since court interpretations of informed consent vary from one jurisdiction to another. . . .

—Adopted a substitute resolution calling for the Board of Trustees, the Interns and Residents Business Section, the Council on Medical Service, and the Council on Medical Education, to develop principles and guidelines for agreements between House staff and their institutions, and to explore the development of a model contract for use by institutions with graduate medical education programs. . . .

—Approved a proposal that the 1977 Annual Meeting be held in San Francisco and the 1977 Clinical Session in Chicago. . . .

—Adopted a report of the Council on Medical Service outlining progress made in persuading the Aetna Life and Casualty Company to limit the use of its surgical predetermination form. . . .

—Endorsed Board of Trustees action in supporting the enactment of legislation for medical devices. . . .

—Referred to the officers of the Interns and Residents Business Section and the Board of Trustees a resolution seeking AMA support for an exemption from federal taxes of the first $3,600 of annual income paid post-doctoral trainees by institutions accredited by the AMA Council on Medical Education. . . .

—Filed a report stressing the record growth of the American Medical Association Education and Research Foundation. . . .

—Adopted a substitute resolution encouraging the observance of due process in disputes involving interns and residents and the institutions in which they work.

Expression of Delegates. Your AMA Delegates express their appreciation to our own House of Delegates, to the Board of Trustees with whom we sit at all meetings, and to the general officers for support, assistance, and continuing communication so that we may be properly prepared to represent your wishes and policy positions.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties—The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted four meetings during the 1973-74 association year consisting of seven meeting days. Eight officers sit with the Board of Trustees at all

meetings. They are the president, president-elect, immediate past-president, secretary-treasurer, speaker, vice speaker, and the two AMA delegates.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

Referrals From the House of Delegates—Matters referred to the Board of Trustees at the 105th Annual Session, 1973, and actions by the House requiring further consideration and implementation include:

a. *Resolution No. 10*—This resolution concerning "Facts on the Health Care Economy" was adopted by the House of Delegates and distributed to each member of the association.

b. *Resolution No. 12*—This resolution concerning creation of a State Department of Mental Health with a physician director and strong physician representation on its governing board was adopted by the House of Delegates and is the subject of a report by the Board concerning 1974 legislative activities.

c. *Address of the President—Recommendations Nos. 1, 2, and 4 and Resolutions Nos. 2 and 11*—These several recommendations and resolutions dealing with composition, representation, and terms of office of the Board of Trustees were amended and adopted by the House of Delegates and referred to an *ad hoc* study committee to bc appointed by the president. They are thc subject of a special report to the House of Delegates by the Committee to Study Realignment of the Board of Trustees *(ad hoc).*

d. *Address of the President—Recommendation No. 3*—This recommendation that the immediate past-president be invited to sit with the Board effective in 1974 was adopted by the House of Delegates effective 1973 and has been implemented.

e. *Honorary Membership Category*—Action by the House of Delegates to create an honorary membership category for laymen who have rendered meritorious service has been implemented and is the subject of a special report from the Council on Constitution and By-Laws.

f. *Expanded Role for the Nurse Practitioner*—Approval for the association to endorse and support necessary legislation to implement an expanded role for the qualified nurse has been implemented and is the subject of a report by the Board concerning 1974 legislative activities.

g. *Legislative Health Voting Index and Organization of Legislative Contact Committee*—Recommcndation to establish a health voting index for each member of the 1972-76 Mississippi Legislature and to organize a legislative contact committee has been implemented and is the subject of a report by the Board concerning 1974 legislative activities.

Nominations for the State Board of Health—Based on action by the House of Delegates at the 1973 annual session, nominations for Mississippi State Board of Health Districts 1 and 3 for six-year terms beginning Jan. 1, 1974, were submitted to Governor William L. Waller. Governor Waller has made the following appointments in this regard: Public Health District 1, Dr. Benton M. Hilbun, Tupelo; Public Health District 3, Dr. John G. Egger, Drew. No vacancies will occur on the State Board of Health in 1974.

CHAMPUS—The association enters its 18th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). An 11 member physician committee serves as the review committee for the program. During the past year the management and efficiency of this program as conducted by the association were cited. CHAMPUS continues to grow with an increase in claims volume of 1.5 per cent and a dollar volume increase of 16 per cent in 1973. During 1973 dependents of 100 per cent totally disabled veterans were included as beneficiaries of the program.

Insurance Programs—The association continues to sponsor a hospitalization group program with Blue Cross and Blue Shield of Mississippi, Inc., general accident, disability, health and life groups with the Continental Casualty Company, and a professional liability program with the St. Paul Companies. There are approximately 2,800 contracts among 1,400 MSMA members in the Blue Cross and Continental Casualty Company group plans and approximately 1,100 MSMA members participate in the professional liability insurance program with the St. Paul Companies. The Board of Trustees annually reviews all programs.

The Continental Casualty Company group programs are administered by Thomas Yates and Company of Jackson. Improvements in these contracts during the year as announced to all MSMA members will include increases in the benefit levels provided under the disability income, hospital payment, excess major, and term life programs.

Budget and Finance—The Council on Budget and Finance met in Novcmber 1973 and prepared the

1974 budget which was presented to the Board in accordance with established procedure. The budget will be presented to the House of Delegates in the customary manner.

Legislative Program—The 1974 Regular Session of the Mississippi Legislature convened in Jackson on Jan. 8, 1974. The Council on Legislation held meetings prior to and during the session for purposes of organizing and monitoring the association's legislative program. Other activities have included production of the weekly legislative newsletter, continuation of the Emergency Medical Care Unit at the Capital, organization of a physicians' legislative contact committee and formulation of a "health voting index" on each member of the Mississippi Legislature.

The state medical association had a four point legislative program for the 1974 Regular Session based on prior actions of the House of Delegates: (1) State Medical Examiner Act; (2) health coverage for the newborn; (3) require uniform claim form for physicians' services, and (4) provide expanded role for RNs. The association also actively supported or opposed other legislative proposals before the 1974 Legislature. A full report will be made in this regard at the annual session.

Mississippi Foundation for Medical Care, Inc.—The Mississippi Foundation for Medical Care, Inc. was organized with the approval of the House of Delegates in 1971. As noted then, voluntary medical care foundations have such principal functions as: (1) to conduct peer review; (2) to provide for the medical profession assuming direct responsibility for and leadership in care delivery; and (3) to provide the most knowledgeable and capable source for (physicians') claims processing and payment information.

At the 1973 annual session the House of Delegates directed the MFMC to proceed to organize the Professional Standards Review Organization Program in Mississippi as required by Public Law 92-603 and within the context of the principles of the MFMC as voluntarily endorsed by its members. The House of Delegates further directed the MFMC to proceed to organize a review mechanism between third party payors and (MFMC) physicians accepting contractural assignments from such third parties. Based on these actions the MFMC has proceeded to develop a peer review plan and "Minimum Standards for Foundation-Endorsed Group Insurance Programs," the latter to cover both physicians' fees and benefit levels.

The MFMC will conduct an annual membership meeting in conjunction with the 106th Annual Session.

Experimental Medical Care Review Organization (EMCRO)—In 1971, the Mississippi State Medical Association received a grant award from the National Center for Health Services Research and Development, Department of Health, Education, and Welfare, to develop a physician sponsored system of evaluating the quality of medical care. The MSMA/EMCRO project will begin its fourth year of operation effective June 1, 1974. The following represents a summary of activities to be conducted by EMCRO during its fourth year:

(1) Test and demonstrate the interfacing of a total hospital care review system to include concurrent review, retrospective review, and continuing medical education;

(2) Continue development and refinement of system to evaluate skilled nursing home services;

(3) Continue development and refinement of a hospital emergency room services review system;

(4) Develop an ambulatory care review system as an extension of the EMCRO hospital and skilled nursing home services review systems; and

(5) Develop standards of patient outcome as method of evaluating health care quality.

Journal MSMA—The JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concluded its 14th year of continuous publication with the 168th issue in December 1973. The thrust of the JOURNAL continues solidly around Mississippi medicine, the association, and the Mississippi physician.

Total pages in Volume XIV, 1973, were slightly down from 1972 due to a decline in advertising. Although advertising on a national level continues to decline, a concerted effort has paid off in more local, instate ads for the JOURNAL. Editorial and scientific articles and personal news items on physicians increased during 1973 and two new monthly departments were added: (1) medico-legal briefs; and network for Continuing Medical Education television schedule.

Among other services the JOURNAL contributes to the association by publishing and absorbing costs are: complete program of the 106th Annual Session; handbook and proceedings of the House of Delegates; Constitution and By-Laws; regular listing of component medical society officers and meeting dates.

The Board wishes to acknowledge special appreciation to the editors and Committee on Publications in the production of this vital membership service. It is not accomplished without time, effort, and devotion.

MPAC—The Mississippi Medical Political Action Committee continues to enjoy the interest and support of Mississippi physicians. This year at the annual American Medical Association-American Medical Political Action Committee Public Affairs Workshop, the Mississippi Medical Political Action Committee received an award for its high percentage of eligible members. We urge continued participation in MPAC and AMPAC by all members.

MSMA-AMA Practice Management Workshop—In conjunction with the American Medical Association, the Board approved the conduct of a "practice management workshop for the new physician," Dec. 17-18, 1973, in Jackson. The program was enthusiastically received by the participants. The Board is investigating the possibility of continuing the workshop on an annual or biennial basis with the cooperation of the University of Mississippi School of Medicine and/or University of Mississippi Medical Alumni Association.

MSMA Membership Recruitment Program—Based on prior actions of the House of Delegates, the president, president-elect, vice presidents, and the Board have actively sought to build an effective membership recruitment program. This year the American Medical Association gave added impetus to the program by offering a recruitment bonus to the component medical society of the new AMA member consisting of one-half of the member's first year AMA dues. The Board is happy to note that there has been a numerical increase in both MSMA and AMA members exceeding the average annual increase in this regard. The association received an award for its increase in AMA members even preceding the new recruitment bonus program. We are hopeful for the future and plans are firm to continue our efforts in this regard.

Organization of the Board—One new Trustee, Dr. Robert S. Caldwell of Tupelo, District 3, was welcomed to the Board during 1973-74. Officers of the Board during the year are Drs. James O. Gilmore, Oxford, Chairman; Everett Crawford, Tylertown, Vice Chairman; and Gerald P. Gable, Hattiesburg, Secretary.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The following amendment to the MSMA Constitution and By-Laws was presented in open session at the 105th Annual Session and officially sent to each component society two months prior to the 106th Annual Session as required by the Constitution and By-Laws. The proposed amendment would create an honorary membership category for laymen who have rendered "meritorious service."

Amend Article IV—MSMA Constitution Section 1. ". . . Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, or *honorary,* according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate *and honorary* shall be construed as active in connection with the rights and privileges accruing thereto. . . ." (New wording italicized)

Amend Chapter I—MSMA By-Laws Section 1. ". . . Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriate accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate *or honorary* must be legally licensed to practice medicine in Mississippi. . . ." (New wording italicized)

Amend Chapter I—MSMA By-Laws Section 3 ". . . Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications (a) active . . . (b) associate . . . (c) emeritus . . . (d) *honorary membership. A layman who has rendered meritorions service may on approval and nomination by the judicial council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office. . . .*" (New wording italicized)

Section 4 ". . . Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) *Honorary members*
(e) Invited guests
(f) Medical students of American Medical Association approved medical schools who are certi-

fied to the executive secretary of the association by their respective deans.

(g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the executive secretary of the association by their respective hospital superintendents in the event they are not associate members of the association.

(h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the executive secretary by their post or base surgeons. . . ." (New wording italicized)

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

Based upon prior actions of the House of Delegates, the Council on Medical Education submitted a "Plan of the Mississippi State Medical Association for a Program of Survey and Accreditation of Institutions and Organizations with Continuing Medical Education of Local Scope and Focus" to the AMA Council on Medical Education for approval. On Dec. 13, 1973, the MSMA headquarters office was notified of one year provisional approval of the "PLAN" for Continuing Medical Education in Mississippi.

Your Council on Medical Education, during the past year, has been coordinating its efforts with its *Ad Hoc* Committee on Continuing Medical Education and the EMCRO. The first problem, recognized by the council in attempting to accredit continuing medical education programs, was a lack of such organized programs on a local hospital basis. Through the EMCRO, however, two pilot projects were funded; one at the Mercy Regional Medical Center in Vicksburg, and one at the Greenwood-Grenada-Winona trade area. These two projects are developing their own local, community hospital-based CME programs. Following the guidelines recommended by AMA and MSMA, these two projects are developing their own "Objectives" and "Plan" in preparation for the accreditation survey.

The initial survey is to be conducted at the Mercy Regional Medical Center in Vicksburg and is tentatively set for May of this year. As a result of this survey, any physician participating in a Continuing Medical Education program at Mercy Hospital in Vicksburg will be able to earn credit hours toward the AMA's Physician Recognition Award or the hours required by the AAFP. This same process will take place with the Greenwood-Grenada-Winona trade area. These three hospitals will have their individual programs, as well as those for the considered region.

As experience is gained by your council and its *Ad Hoc* Committee matures, additional surveys for Continuing Medical Education program accreditation will be scheduled. With this in mind, a manual, to be used by hospitals interested in developing a community hospital-based Continuing Medical Education program, will be compiled. This manual is the main objective for the next year's efforts.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties—The Council on Medical Service is a constitutional body of the House of Delegates, consisting of nine members, one from each association district, elected for terms of three years each. There are three ex officio members who are our president, president-elect, and secretary-treasurer. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted by five committees, four constitutional and one ad hoc. These embrace a wide range of subject areas, including maternal and child care, blood and blood banking, mental health, nursing, and college health.

Committee on Nursing—The Committee on Nursing serves as the association's liaison committee with a similar committee of the Mississippi Nurses Association. Based on recommendations of the committee contained in "Supplemental Report A of the Council on Medical Service" to the House of Delegates at the 1973 annual session, the committee has worked with the MNA in formulating and coordinating legislation to provide for an expanded role for the RN based on local needs and desires and as approved by the Mississippi State Board of Health and Mississippi Board of Nursing. HB 436, 1974 Regular Session of the Mississippi Legislature, provides statutory authority to implement this expanded role concept. In anticipation of final favorable action on the bill the committee has offered its services to the Mississippi State Board of Health in a consulting capacity to assist in setting standards for the expanded role of the nurse and this offer has been accepted.

The committee is also concerned with patient care

provided in nursing homes and in this regard the committee has met with professional staff of the Mississippi Medicaid Program's Nursing Home Services staff. The February, 1974 JOURNAL MSMA article entitled "Problems, Needs, and Preparation of Nurses in Nursing Homes in Mississippi" represents an agenda for future action to improve patient care provided in nursing homes in Mississippi.

Committee on Maternal and Child Care—The Committee on Maternal and Child Care continues its study of maternal deaths in Mississippi. A report on "Maternal Mortality in Mississippi: 1970-1971" appeared in the March 1974 JOURNAL MSMA. Based on numerous questions and concern over the status of abortion in Mississippi in view of both the U. S. and Mississippi Supreme Courts' decisions on this subject, the committee prepared a "Statement on Abortion" for adoption by the association as a "discussion" of the legal and medical aspects of abortion. This was published in the January, 1974 JOURNAL MSMA. The committee is presently revising its "Maternal Health Desk Cards" for distribution within the next few months.

Committees on Mental Health, Blood, and College Health (ad hoc)—These committees of the council have continued activities in their respective areas of assigned interest. Although not directly involved in efforts to reorganize the state's mental health programs, individual members of the Committee on Mental Health, the association's Council on Legislation, and the Mississippi Psychiatric Association have been actively involved in formulating legislation before the 1974 Mississippi Legislature dealing with this subject matter. The Committee on College Health has held meetings over the past several months devoted to drafting a survey form for studying health services offered in Mississippi colleges and universities and the chairman of the committee represented the association at the 1973 AMA-American College Health Association Annual Meeting.

Other Council Activities—The council has considered other subject matter following within its sphere of assigned interest and wishes to bring the following information and recommendations to the attention of the House of Delegates for such action as deemed appropriate.

Public Law 93-222: Health Maintenance Organization Act of 1973. The Congress passed and the President signed on Dec. 29, 1973, Public Law 93-222. This law creates a new title in the Public Health Service Act which authorized assistance for the *development* and *operation* of what are to be known as Health Maintenance Organizations (HMOs).

As defined by law, an HMO must be a legal entity which is composed of those health professionals necessary to provide the services required of an HMO (noted below) the majority of such health professionals being licensed physicians or osteopaths. The members of the legal entity must as their principal professional activity and as a group responsibility engage in the coordinated practice of their professions for an HMO and must pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan.

The HMO's services must be prepaid by its subscribers. A set monthly premium is charged and such premiums must be "community rated," i.e., payments are determined on a per-person or per-family basis and may vary with the number of persons in a family but will be equivalent for all individuals and for all families of similar composition. Each HMO must schedule a 30 day "open enrollment" period each year and no prospective subscriber may be turned down as a "poor risk" unless the HMO's subscriber rolls already include too many "poor risks."

The HMO must provide the following "basic" services to all subscribers on a 24 hour basis: (a) physician services; (b) emergency services; (c) short term (not to exceed 20 visits) outpatient evaluative and crisis intervention mental health services; (d) medical treatment and referral services for the abuse of or addiction to alcohol and drugs; (e) diagnostic lab and x-ray services; (f) home health services; (g) preventive health services (including family planning, infertility services, preventive dental care for children, and children's eye examinations).

Federal HMO funding is provided as follows: (1) grants of up to $50,000 to public and non-profit groups to support HMO feasibility studies; (2) grants of up to $125,000 to a qualified (HMO) group for planning and development or for expansion of existing HMO-type health plans; (3) HMO operational loans of up to $2.5 million to offset losses incurred during the first 36 months of operation.

Other important HMO provisions are: (1) no state may establish or enforce laws preventing or restricting the development of HMOs; (2) HMOs must give their subscribers one-third representation on all policy-making bodies and must provide health education services to subscribers and set up procedures to resolve grievances between subscribers and

the HMO; (3) every employer covered by the minimum wage laws must offer his employees an HMO option, if one is available, in lieu of their present health insurance coverage—any increased premium costs, however, must be borne by the employee; (4) HMOs are encouraged to serve rural and "medically underserved" areas.

Recommendation. As noted above, a state cannot enforce laws which restrict and/or prevent the operation of HMOs as provided for by Public Law 93-222. The legal status of an HMO in Mississippi is hazy. A bill was introduced during the 1974 session of the Mississippi Legislature which would have established some basic standards for HMOs to be administered by the State Insurance Commissioner. The bill died in committee and it now appears that the only state laws relating in any way to an HMO are those under which Mississippi Blue Cross and Blue Shield, Inc. is organized. The Council on Medical Service recommends that the association furnish appropriate leadership and guidance in defining the legal status of HMOs in Mississippi.

Exploring Medicine and the Allied Health Careers Programs—The Boy Scouts of America is seeking the support and guidance of the Mississippi State Medical Association and its constituent societies in organizing Medical Explorer Programs in Mississippi. The BSA Medical Exploring Program is similar in format to other BSA Exploring Programs in medicine, banking, law enforcement, etc. It is open to young men and women 15 to 21 years of age and at present some 46,000 young people belong to 1,700 medical explorer posts. In 1972 the American Medical Association provided a three-year grant to the BSA to help expand the Medical Explorer Program.

The two main ingredients necessary to form a medical explorer post are young adults interested in health careers and sponsoring organizations. It is in regard to the latter that the medical society can play an important role. Sponsorship of Exploring involves the development of a program, providing meeting facilities, selection and approval of leadership, and making necessary resources available. The local BSA Exploring Division in Mississippi will assist with program development, training of personnel, volunteer and professional staff support, central registration and office services, and local and national events and activities in support of the post. The program is provided without cost to the sponsor although many organizations budget modest amounts to assist the Explorers with their activities.

Recommendation. The Council on Medical Service recommends the association's formal support and guidance in organizing the BSA Medical Exploring Program in local medical societies throughout the state.

The Physician's Assistant—At the 105th Annual Session, the House of Delegates considered the new and expanding health profession called the "physician's assistant" and went on record as "opposing the licensing of physician assistants . . ." and stating "that such health professionals should work under the direct supervision of physicians." During the 1974 Regular Session of the Mississippi Legislature, confusing and potentially unfortunate efforts were made to recognize and regulate the physician assistants. Such efforts were prompted, among other reasons, by the fact that there are physicians in Mississippi employing PAs.

Recommendation. The council recommends that the House of Delegates reaffirm its position on physician assistants (i.e., PAs not be licensed and work under the direct supervision of a physician) and further urge legislation in this regard to empower the physician members of the Mississippi State Board of Health to approve and certify a physician's employment of a physician's assistant and to approve and certify proposed functions of the physician's assistant as described by his physician employer. The use of the term "physician's assistant" in this context refers solely to the new occupations being developed to assist the physician in delivery of personal care services.

Amendments to the Medicare-Medicaid Programs—The council has considered the extensive amendments to the Medicare and Medicaid Programs enacted by the Congress in Public Law 92-603. These amendments were the basis of an article entitled "Report of the Council on Medical Service: Medicare-Medicaid Amendments" published in the December 1973 JOURNAL MSMA.

Recommendation. The council urges each member's attention to the article "Report of the Council on Medical Service: Medicare-Medicaid Amendments." Further, the council has considered the nomenclature of physician services used by Medicare, Medicaid and other third party payors and the relationship of physicians' usual, customary, and reasonable fees in Mississippi to payments for physicians' services by Medicare, Medicaid, and other third party payors. The heretofore "secret" Medicare prevailing fee guidelines were made available by a court

order. The council is aware of and commends the work of the Mississippi Foundation for Medical Care in this subject area based on actions of the House of Delegates. The council recommends that the American Medical Association be called upon to furnish leadership in compiling, analyzing, and publishing Medicare "prevailing fee guidelines" used throughout the United States.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates, charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the seven scientific sections and the secretary-treasurer of the association, a total of 15 members.

106th Annual Session. Planning and organization of the 106th Annual Session was initiated in the summer of 1973. The format suggested in the By-Laws and approved by the House of Delegates has been continued with general sessions centered around broad areas of specialty interests. To the maximum possible extent, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 15 specialty societies have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various non-scientific but medically related bodies will meet during May 6-9. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Woman's Auxiliary and its concurrent annual session with us.

Medical television on the agenda for the 106th Annual Session will feature films sponsored by the the Davis and Geck Suture Company and coordinated with presentations before the seven scientific sections. Also to be shown are a State Board of Health film on alcoholism and a Wayne State University film on respiratory distress syndrome.

Technical Exhibit. Your council notes that ethical pharmaceutical firms, suppliers, and others eligible for purchase of space in our Technical Exhibit are declining our invitation to participate in growing numbers. This is not confined to Mississippi, because other state medical associations, major state specialty societies, and national organizations are having the same experience.

Federal drug legislation, changing concepts in marketing, and tighter budgets for advertising have taken a toll of technical exhibit revenues. We have circularized more potential exhibitors than ever before and are placing emphasis on attracting exhibits from investment and other interested firms. We continue to do all things possible to increase this participation.

Presentations in the scientific exhibit number over 20 this year. We urge every member and guest to view these educational exhibits and the technical exhibits.

New Features. Your council, in an effort to increase attendance and participation, has instituted several new features this year. On Tuesday morning an association-wide fellowship breakfast will be held. A poolside hamburger party for teenagers is planned and babysitting facilities and kiddie movies will be available. A special floor show is planned for Tuesday night on the Top of the Sheraton. An extensive promotional campaign is being conducted through the JOURNAL MSMA and the Blue Sheet.

Headquarters Hotel. The annual session will be held at the Sheraton-Biloxi for the fourth year. The council chairman and the MSMA executive staff have conducted extensive consultations with the Sheraton staff in the hope of improving service in the hotel.

Expression of the Council. Your Council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 106th Annual Session of the association.

College of Radiology Sponsors CME Courses

The American College of Radiology is sponsoring a series of continuing education symposia during 1974. These courses, all of which are approved for 15 hours of Category I accreditation for the AMA Physicians' Recognition Award, are held on weekends in various cities throughout the country.

The 1974 series includes symposia on the skeletal system, the pediatric chest, and the gastrointestinal system. Each symposia uses the multiple viewbox technique, which enables each pair of participants to work from their own set of teaching radiographs. Because of space limitations imposed by this technique, registration is limited to 200 physicians at each symposia. The fee for each course is $200 for ACR members and $240 for non-members.

A seminar on radiology of the skeletal system will be held June 24-25 in Chicago, in conjunction with the American Medical Association's annual meeting, June 22-27. (Because of the AMA meeting, this seminar will be conducted on Monday and Tuesday, rather than on a weekend, and the registration fee of $200 for ACR members also applies to AMA members.)

Seminars in the series on the pediatric chest will be held May 31-June 2 in San Diego, and Sept. 6-8 in Tampa, Fla. A seminar in the series on radiology of the gastrointestinal system will be held Oct. 18-20 in Chicago.

The subject matter for the skeletal system courses will consist of presentations of tumors and tumor-like conditions of the skeleton (solitary bone lesions) and the arthritides. The practical aspects of skeletal radiology—those entities which commonly are encountered by the practicing radiologist—will be featured under both major headings.

The subject material for the pediatric chest courses will cover obstructing lesions of the airway; inflammatory disease; systemic diseases as manifested in the chest; thoracic and mediastinal masses; and conditions peculiar to the newborn infant.

The faculty for the San Diego and Tampa seminars on the pediatric chest is headed by Drs. John A. Kirkpatrick and Donald H. Altman, and they will be joined by Drs. Edward Singelton and John Gwinn.

The Chicago seminar on the GI system will emphasize observation, analysis, and evaluation of basic radiologic features of barium studies of the GI tract. The faculty for this symposium is headed by Dr. Bernard S. Wolf and he will be joined by Drs. Thomas C. Beneventano, Arthur R. Clemett, Alexander R. Margulis, Richard H. Marshak, Morton A. Meyers, William B. Seaman, and Walter M. Whitehouse.

For registration information, contact the American College of Radiology, 20 N. Wacker Dr., Chicago, Ill. 60606.

Miss. Choctaw Students Consider Health Careers



Young Choctaw Indian high school students from Philadelphia are attending a medical science institute for students interested in medical careers at the University Medical Center. The 18 students make the 80-mile bus trip every Saturday to get help in planning their futures. Peter Stewart, right, coordinator of minority student affairs, talks with some of the students and their counselor, Lee Bacon, second right, about what they'll learn during the morning sessions. Stewart says that UMC faculty cover practically every facet of medicine—research, surgery, orthopedics, electrocardiography, family and infant medicine, anesthesiology, obstetrics and gynecology, radiology, pathology, health related fields, and specialized medicine.

CLASSIFIED

WANTED: Internist or family practitioner to replace loss in clinic. Contact Long, Dees and Edwards Clinic, 775 North State Street, Jackson, Miss. 39201. 601-352-0753.

JOIN

MPAC

TODAY

MEDICAL DIRECTOR

The Board of Trustees, Eleemosynary Institutions is seeking physicians applicants for a fulltime position as medical director at each of the following state operated acute general hospitals: **South Mississippi State Hospital, Laurel; Kuhn Memorial State Hospital, Vicksburg;** and **Natchez Charity Hospital, Natchez.**

There would be no initial cost to the physician for equipment, office expenses, or secretarial expense. Estimated income, $50,000 annually. Physicians interested in these positions should contact the following board members; Joe M. Ross, M.D., The Street Clinic, Vicksburg; J. P. Tatum, M.D., 1314 19th Avenue, Meridian; Charles A. Hollingshead, M.D., 103 S. 12th Avenue, Laurel; John R. Young, M.D., 55 Sergeant Prentiss Dr., Natchez; O. B. Crocker, M.D., Bruce, or the Board's Office, 1404 Woolfolk State Office Building, Jackson, Mississippi 39201.

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IN CONCLUSION

Accidents caused an estimated 116,500 deaths in the U.S. in 1973, about 500 fewer than in 1972, according to the Metropolitan Life Insurance Co The 1973 provisional mortality rate from accidents was 55.5 per 100,000 population, compared with 56.2 the previous year. The estimated rate for 1973 is the lowest since 1964. A decrease in the death toll from motor vehicle accidents was in large part responsible for the reduction in the loss of life from accidents during the past year.

The Senate Select Committee on Nutrition and Human Needs, after investigating nursing homes in 10 states over six-month period, discovered a number of deficiencies in nursing home dietary programs. Report states that "poor food is the most current abuse in today's nursing homes." Dietary departments in more than 50 per cent of the facilities visited "demonstrated an attitude toward therapeutic diets which often approached a disregard to the patient's health."

The Council on Medical Education of the AMA, in collaboration with the American Association of Medical Assistants, has been recognized by the U.S. Commissioner of Education as an official agency to accredit educational programs for medical assistants. AMA and AAMA have collaborated on accreditation of medical assisting programs since July 1969 when curriculum standards were approved by AMA House of Delegates. To date 58 one-and two-year programs have been approved.

HEW Secretary Caspar Weinberger announced in a press release on Mar. 14 the final designations of local PSRO areas. When the proposed designations were made on Dec. 20, 1973, 182 areas were specified. Under the final designations there are 203 geographic areas in which PSRO's are to be formed. The Secretary indicated that "HEW is now prepared to accept applications for contracts from qualified physician organizations to plan PSRO's or to begin conditional operation."

Nearly half of the elementary school students participating in a recent survey accepted ALL television commercials for health-related products as true, researchers reported in March issue of Pediatrics. The 281 students surveyed believed 70 per cent of the 781 commercials viewed. Survey was undertaken to determine how much T.V. influenced health practices of children. Whether parents had used the products made significant difference in whether children believed commercials.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

MAY 1974



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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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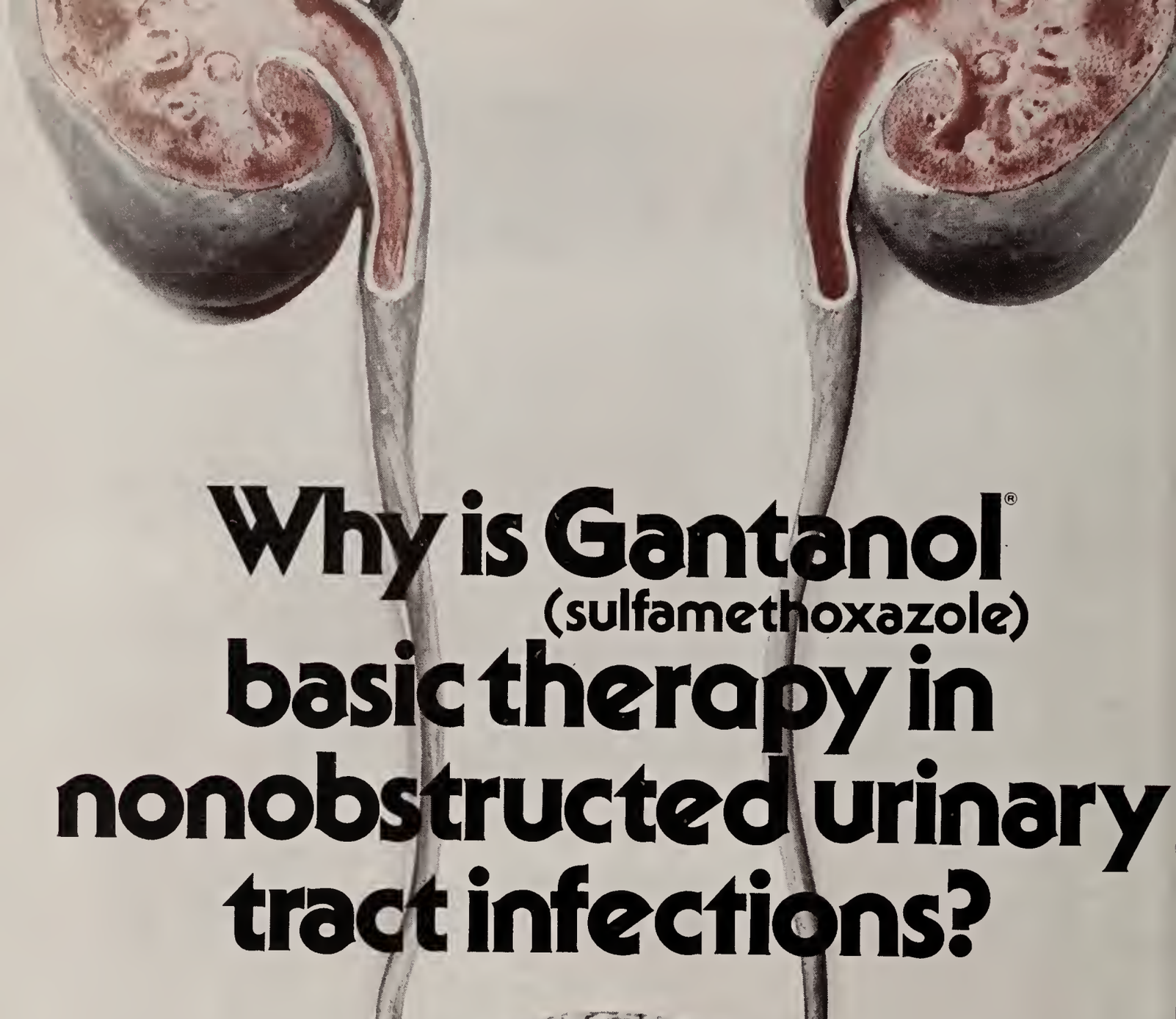
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Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

NEWSLETTER

May 1974

Dear Doctor:

Physicians who will be traveling to the Coast for the 106th Annual Session of MSMA on Sunday, May 5, may wish to take advantage of a new service by the Mississippi A and I Board. The Board now has available a list of service stations in the state which stay open on Sunday. You may obtain this information by dialing toll free 1-800-222-0040.

> In Jackson, these are open: Day's Inn Self Service, I-55 S; K & S Gulf, I-55 S; Mid Continent Truck Plaza, I-20; I-20 & 49 Truck Plaza, Hwy 49 S; Briarwood Premier, I-55 N. Hattiesburg has: Travelers Truck Stop, Hwy 49 S; Stucky's, Hwy 49 N; and Billups, Hwy 11 S.

Many medical students need financial assistance and many local towns need physicians so the Ole Miss Medical Alumni are launching a program whereby the towns provide assistance and the student agrees to practice there for a certain time. A bulletin of interested students will be developed, said Dr. W. E. Bowlus, chairman.

Dr. Richard E. Palmer was elected chairman of the AMA Board of Trustees at the March meeting. Dr. John M. Chenault was named vice chairman. Elections followed appointment of Board Chairman Dr. James H. Sammons as AMA executive vice president designate to succeed Dr. Ernest B. Howard, who retires March 1, 1975.

The decline in the infant mortality rate in the U.S. continued in 1973. The National Center for Health Statistics reported last year's infant mortality rate to be 17.6 per 1,000 live births, the lowest in history. The rate was 18.2 in 1972, 19.2 in 1971 and 19.8 in 1970.

May is National High Blood Pressure Month. America's private, professional, voluntary, state and federal organizations have worked together in a collaboration of efforts called the National High Blood Pressure Education Program to make both the public and health professionals more aware of the prevalence and danger of hypertension.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Physician Shortage Will End by 1980

The shortage of physicians in the United States will be over by 1980, says a recent report in the *Journal of the American Medical Association.*

In fact, there probably is no shortage today in terms of overall numbers. Rather, there are not enough physicians in the primary treatment areas, and there is maldistribution of doctors across the nation, says Dr. James K. Cooper and Karen Heald in the article. They are with the Rand Corporation, Washington, D. C.

The frequently quoted "shortage of 50,000 doctors" is probably an exaggerated figure, the report declares. The total number of physicians has more than kept up with the growth of the population. In 1950, the total number of active nonfederal physicians per 100,000 population was 119. In 1971, the ratio had increased to 152.

Many more physicians today are specialists than in past years, and although the total number of physicians and the physician-to-population ratio in this country is greater now than ever before, the ratio of primary care providers has decreased, and there is considerable disparity in the number of physicians in different geographic areas, they say.

A recent report from the Department of Labor predicts an increase in total need for physicians in the next few years, because of the growing proportion of the population who are elderly, and because of an anticipated increased effort to provide care for persons who are now underserved. It is estimated that by 1980 there will be a total need for between 413,000 and 436,000 physicians.

Several factors are operating to meet this high level of need. Medical schools are expanding facilities and accelerating medical education. The schools will be producing 17,000 new doctors a year by 1980. Also the number of foreign physicians moving to the United States is expected to remain high. The number of physicians will be greater than 436,000 by 1980, they say. There are now more than 360,000.

"These projections of need and supply lend great credence to the remarks of Dr. Walter C. Bornemeir, past president of the AMA, who, referring to the doctor shortage, exclaimed, 'It'll all be over by 1980.' It is time now to direct efforts at the real problems, physician maldistribution and a relative shortage of primary care physicians."

Rondomycin®
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CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

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DATELINE

AMA Sets Annual Convention

Chicago, Ill. - The 123rd annual convention of the American Medical Association will be held June 22-27, 1974, in Chicago. Preliminary program for the convention, estimated to draw 20,000 registrants, was published in the April 15 issue of JAMA. A total of 54 scientific courses are scheduled along with 36 postgraduate courses. New this year are fireside forums involving the six Chicago medical schools.

M.D. Pay Bill Clears Conference

Washington, D.C. - House and Senate conferees have reached agreement on S. 2770, which authorizes special pay for medical officers in the uniformed services. Under the conference committee bill, bonuses of up to $13,500 a year would be authorized for medical officers who enter into active duty agreements with uniformed services. The committee deleted special pay provisions for dentists and optometrists.

Kids With Migraine Seen as Fragile

Evanston, Ill. - Twelve out of 13 children participating in a study on migraine headaches were viewed as fragile, "incompetent to deal with one or more of the ordinary demands and stresses of life" by parents and siblings, a UCLA researcher reports in Pediatrics. This attitude may cause parents to overreact and overprotect the child, contributing to his frustration which manifests itself in the migraine.

Health Spending Shows Growth

Washington, D.C. - The U.S. health care bill reached an estimated $94.1 billion in fiscal 1973, up 11% from 1972 but the lowest rate advance in several years. The gross national product recorded its highest growth rate in years -- 10.9%. Because both measures registered similar rate gains, health spending remained the same share of GNP -- 7.7%, reports Social Security Administration.

Johnson Foundation Reports on 1973

Princeton, N.J. - The lack of a dependable system of ambulatory general medical care is the nation's most pressing health problem, Dr. D. E. Rogers, president of the Robert Wood Johnson Foundation, said in the 1973 annual report. The report features a discussion of the key elements in a general health system and marks the completion of the second year as a national philanthropy concerned with health care.

AHA Urges Resuscitation Training

Training Americans in the latest techniques of saving lives of heart attack victims is advocated in a supplement to the Feb. 18 issue of the *Journal of the American Medical Association.*

The supplement was prepared by the American Heart Association and the National Academy of Sciences-National Research Council as the outgrowth of a national conference on cardiopulmonary resuscitation (CPR) held last summer. It updates an earlier report published in 1967, also as a supplement to *JAMA.*

"Sudden death from heart attack is the most important medical emergency today," the supplement declares.

About one million persons in the United States each year have heart attacks. More than 650,000 die annually of heart disease. About 350,000 of these deaths occur outside the hospital, usually within two hours following the attack.

Among many important considerations in saving lives of heart attack victims is for the public as a whole to know the symptoms—persistent chest-shoulder-arm pain, sweating, nausea and vomiting, palpitation of the heart and fatigue, the report says.

If you recognize the symptoms and know that you probably are having a heart attack, it is then highly important to know how to get into the emergency medical system promptly. Each individual in the nation is urged to have a well-formulated plan for seeking help immediately. This plan will vary with the available facilities in his community.

The report recommends that Basic Life Support (BLS) training programs be extended to the general public, starting with groups such as policemen, firemen, lifeguards, rescue workers, high-risk-industry workers and families of heart disease patients. Training should then be expanded to include school children and other segments of the general public. Training should be according to standards of the American Heart Association.

BLS is emergency first aid. This consists of knowing how to recognize airway obstructions, breathing arrest and heart arrest, and how to cope with these

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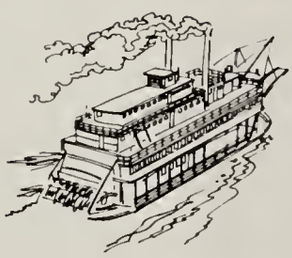

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conditions. Advanced Life Support includes BLS but also encompasses the use of advanced equipment, drugs and other activities that must be done by highly trained units under the supervision of a physician.

It still is possible to reduce the risk of heart attack by changes in basic life style, but many people refuse to do so.

"A low animal fat diet, regular exercise and cessation of cigarette smoking will never become very popular," says Dr. Robert H. Moser, editor of *JAMA*, in an accompanying editorial.

"In the meantime, there is hope in the fact that the American Heart Association and the National Academy of Sciences-National Research Council have assumed a realistic posture. They have not given up on the public—they continue to propagandize about the advantages of a return to a more spartan way of life, but they have directed their major energies in a direction more likely to get pragmatic results.

"They are out to train a vast cadre of physicians, physicians' assistants, and the public at large, in the techniques of rapidly instituted, intelligently delivered cardiopulmonary resuscitation."

Many physicians are untrained or poorly trained in CPR and increased efforts are called for in the area of physician education, says Dr. Stephen Carveth of the AHA Committee, in another editorial. The Council on Scientific Assembly of the AMA has planned a formal educational program, offering to physicians courses in both Basic and Advanced Life Support at the AMA annual convention next June in Chicago.

Colposcopy Course Set for June

A course on colposcopy and the cytologically suspect uterine cervix will be held June 17-18, 1974, at the Lexington Hilton Hotel.

The course is sponsored by the University of Kentucky College of Medicine and there will be a registration fee of $250. For further information, contact Dr. Ronald D. Hamilton, College of Medicine, University of Kentucky, Lexington, Ky.

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Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J



JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
May 1974, Vol. XV, No. 5

ORIGINAL PAPERS

Fiberoptic Colonoscopy and Polypectomy

PABLO Y. VARELA, M.D., and
WILLIAM F. EASLEY, JR., M.D.
Meridian, Mississippi

The authors give a preliminary report of their experience with the removal of polyps via the fiberoptic colonoscope. They feel that the procedure does have definite advantages and should be strongly considered in today's management of colonic polyps. Clinical experience with six patients who underwent colonoscopy and polypectomy is detailed and the proper technique explained.

THIS PRELIMINARY report deals with our early experience with the removal of polyps via the fiberoptic colonoscope. Although our experience is still quite limited, we feel the procedure has such definite advantages that this preliminary report is justified. It has been only recently that polyps high in the colon have been removed by the use of the fiberoptic colonoscope. Until this time, the only way to distinguish between benign and malignant polyps high in the colon has been by laparotomy. This has always presented a problem regarding the management of polyps that were beyond the reach of the sigmoidoscope. The decision whether to operate or not has been extremely difficult especially in elderly patients who were considered poor surgical risks.

We recently acquired the ACMI Wappler Endoscopic polypectomy snare that was designed for use through the fiberoptic colonoscope. It is our intention in writing this preliminary report to show that such a procedure does have definite advantages and should be strongly considered in today's management of colonic polyps.

CLINICAL EXPERIENCE

Six patients have undergone colonoscopy and polypectomy in our institution. Most of these polyps ranged in size from 1 cm. to 5 cm. in diameter. There was one case of a villous adenoma that was approximately 10 cm. in diameter. The five polyps were all found beyond 25 cm. The villous adenoma was located approximately 10 cm. from the anal opening. All polyps were single. The polyps were removed in single stage procedure. However, the villous adenoma necessitated removal in a piece by piece method. All of the polyps we have removed thus far have proven to be benign. We have had no complications with the procedure. The patient with the villous adenoma had some slight bleeding, but this was readily controlled by the use of electrocautery. None of the patients done thus far has complained of pain postoperatively.

From the Gastroenterology Section of the Department of Medicine, Rush Medical Group, Meridian, Miss.

TECHNIQUE

Procedures were performed without anesthesia in our endoscopic room. Depending on the location of the lesion, the fixation of the bowel or the acute angulation of the rectosigmoid, the removal of the polyp may take from 15 minutes to 1 hour. All patients tolerated the procedure quite well.

All of the patients were admitted to the hospital the day before the endoscopic procedure. A complete history was obtained and physical examination performed. Most of the patients were advised to stay on a clear liquid diet for approximately three days prior to admission. In addition, the patients were given laxatives each evening for three days prior to

admission. At the time of admission, each patient was screened for coagulation defects, including prothrombin time, platelet count and bleeding time. The surgeons were notified on each occasion that the procedure was being done so that if complications occurred, the patient could be sent to surgery for immediate laparotomy.

The patients were given 10 mg. of Valium intravenously for sedation. We have found that this usually suffices. Occasionally, the use of intravenous Demerol is necessary. When severe spasm of the rectosigmoid is encountered, the patient is given 20 mg. of Bentyl intramuscularly. On the day of the procedure the patient is kept NPO and given enemas until clear.

The patient is asked to lie comfortably in the left lateral recumbent position. The colonoscope which is well lubricated is introduced gently into the anal opening. An attempt is made to use the least amount of air insufflation as possible. While the polyp is being pursued, examination of the colonic mucosa is done. As soon as the polyp is identified, the polypectomy snare is used. The technique involves getting the snare looped over the head of the polyp and then maneuvering the snare down onto the base of the polyp. The loop is then gently tightened to slowly cut off the blood supply. Strangulation is accomplished in this way and is readily evident by a color change from pink to dark red or a purplish cyanosis. A few minutes of strangulation greatly decreases the chance of bleeding after the pedicle is transected. The larger the pedicle, the longer the period of strangulation. After an adequate period of strangulation, the electrocautery power is applied. We are presently using the Wappler Pneumotome 100, which is a new electrosurgical unit that combines both cutting and coagulation power.

Following the polypectomy, the patient is returned to his room. He is continued on a liquid diet for 24 additional hours. During this 24 hour period, the patient is observed for complications. After 24 hours with no complications, the patient is usually discharged. Patients are told to avoid strenuous activity for approximately one week and are given clinic follow-up. The total hospital stay is approximately three days. After successful removal of the polyp, the entire specimen is submitted to the pathologist. If the resected polyp does not show invasion, the patient is advised to have repeat colonoscopic examination within at least six months. Early carcinoma confined to the head of the polyp very rarely metastasizes and therefore polypectomy is considered curative. When massive carcinoma is discovered, definitive surgical intervention may be undertaken without further delay.

Explosion is one of the hazards which has been reported. However, this may be avoided by strict observance of the following conditions. The colon must be entirely free of any fecal material, and there must be an adequate exchange of gases. Recently we have begun using carbon dioxide to exchange with the gas that is formed in the colon. This is an added precaution. In the opinion of Shinya and Wolff, explosion is not a hazard if the above precautions are followed.

DISCUSSION

Our experience with this new procedure has been very gratifying. It has proven to be a safe, effective and reliable diagnostic and therapeutic modality. The procedure has considerably reduced the cost for our patients. In a study in the Peter Bent Brigham Hospital, the total cost of a colonoscopic polypectomy was $1,075. That for a transabdominal polypectomy was approximately $3.241. Our experience has been about the same. Other advantages include early return to work and normal daily activities commencing on the average of two to three days after discharge as compared to one month after abdominal laparotomy. The other distinct advantage is the freedom from the long and painful postoperative period. As previously mentioned, none of our patients complained of any pain post-polypectomy. There are some limitations to this procedure. Some conditions make the procedure quite difficult. These include previous pelvic surgery, previous pelvic inflammatory disease, severe diverticular disease with narrowing of the lumen, and a markedly redundant sigmoid colon. Acute colonic inflammatory disease, acute diverticulitis, recent abdominal surgery, aortic or iliac aneurysm, recent myocardial infarction and perforating disease of the colon should be considered contraindications to this procedure. ★★★

Rush Medical Group, P.A. (39301)

REFERENCES

1. Wolff, W. and Shinya, H.: Polypectomy via the Fiberoptic Colonoscope. NEJM 288:329-332, 1973.
2. Dehyle, P.: Flexible Steel Wire for the Maintenance of the Straightening of the Sigmoid and Transverse Colon During Colonoscopy. Endoscopy 4:36-38, 1972.
3. Bloom, B. S., Goldhaber, S. Z., Sugarbaker, P. H. and and O'Connor, N. E.: Fiberoptic: Morbidity and Cost. NEJM 288:367-368, 1973.
4. Wolff, W. and Shinya, H.: Colonofiberoscopy. A New and Valuable Diagnostic Modality. Am. J. Surg. 123:180-184, 1972.

Intracranial Arteriovenous Malformations in Sisters: A Case Report

JOHN W. LAING, M.D., and
ROBERT R. SMITH, M.D.
Jackson, Mississippi

THE CONGENITAL arteriovenous malformation is not a common lesion. Olivecrona described only 125 such cases encountered in a 33 year period of neurosurgical practice.[1] Of the 6,368 cases registered in the *Cooperative Study of Intracranial Aneurysms and Subarachnoid Hemorrhage,* 563 of these were identified as having an arteriovenous malformation of some type. Coexisting arteriovenous malformations and intracranial aneurysms were found in 1.4 per cent of the patients. The overall incidence of AV anomalies to ancurysms, however, was 1:6.5. Although earlier studies have seemed to indicate a male preponderance for AV anomalies, this finding was not substantiated in the cases reported from the cooperative series.[2]

Familial vascular malformations must be an even more uncommon finding. Since these anomalies are occasionally found in asymptomatic patients, and in association with other vascular anomalies, such cases may exist and have remained undiscovered because of their asymptomatic nature.

In the case of intracranial arteriovenous malformations, there are few reports to substantiate a familial relationship. Tonnis and Lange-Cosack described arteriovenous malformations confirmed at necropsy in two siblings.[3] More recently, Clark reported autopsy confirmed cases of cavernous angiomata of the brain in a man and his daughter.[4] There are no reports describing familial arteriovenous malformations confirmed radiographically and successively managed surgically. In the cases to be described in the following reports, two members of the same family presented to the University Medical Center with subarachnoid hemorrhage and intracranial arteriovenous anomalies.

From the Division of Neurosurgery, University of Mississippi School of Medicine, Jackson, Miss.

The congenital arteriovenous malformation is not a common lesion and familial vascular malformations are even more uncommon. The authors discuss arteriovenous malformations occurring in sisters and presenting as subarachnoid hemorrhage. The lesions were documented angiographically and successfully managed surgically at the University Medical Center in Jackson.

CASE REPORTS

Case No. 1. This 16-year-old white female presented in March of 1968 with sudden onset of headaches, accompanied by bloody and xanthochromic cerebrospinal fluid. Physical examination at the time of her admission disclosed nuchal rigidity and bilateral blurring of the disc margins. There were no cutaneous vascular nevi present. Routine skull films were normal. On angiography, an arteriovenous malformation filling primarily from the right anterior cerebral artery was found. (See Figure 1.) The patient was treated conservatively, and released after two weeks of hospitalization. Subsequently, she developed convulsive seizures of increasing severity and frequency. Her seizures were managed initially with Dilantin and Phenobarbital but ultimately conservative management failed. On Oct. 4, 1971, she

underwent a right fronto-parietal craniotomy where multiple nutrient vessels were first ligated and then total excision of the arteriovenous malformation was accomplished. Histological sections of the malformation are shown in Figure 2. Postoperatively, the patient had no localizing neurological findings. She has returned to her employment and has had no further seizures up to the time of this report.



Figure 1. Right carotid angiogram demonstrating right parasagittal AV malformations feeding from a dilated callosomarginal artery.



Figure 2. H and E section of AV malformation from Case No. 1. There are multiple dilated hyalinized vessels with interposed glial background.

Case No. 2. A 29-year-old white female, sister of the patient in Case No. 1, presented to the University Medical Center in February of 1972, with severe headaches of catastrophic onset. The headache was predominantly in the right retroauricular region but was generalized to some extent and was associated with vomiting. She also had no cutaneous vascular lesions. Lumbar puncture produced bloody cerebrospinal fluid. On admission, the patient was alert and oriented and excluding mild nuchal rigidity, there were no neurological findings. Routine skull x-rays were normal. The isotope encephalogram showed an area of increased uptake in the right posterior temporal area and carotid angiography confirmed a vascular blush in the same region. This finding was confirmed and further illucidated by right brachial angiography. (See Figure 3.) The arteriovenous malformation filled primarily from the right posterior cerebral artery. In March of 1972, a right temporal craniotomy was carried out. Multiple draining veins in the right temporal lobe were encountered which were filled with bright red arterial blood. The primary nutrient arterial vessel originating from the

posterior cerebral artery was ligated and excision of this malformation was accomplished. Postoperatively, there were again no localizing neurological findings. The patient's course was uncomplicated and she has since returned to her employment.

COMMENTS

Intracranial vascular malformations are usually regarded as congenital in origin and almost universally



Figure 3. Right brachial angiogram demonstrated a posterior temporal AV malformation filling primarily from a dilated posterior cerebral artery.

these lesions have been attributed to developmental malformations of the cerebral vascular system.[1] Whether hereditary factors or environmental conditions play a major role in their development, however, has been the subject of considerable speculation. In the case of the capillary hemangioblastoma associated with Von-Hippel-Lindau's disease, a familial relationship has been found in approximately 20 per cent of the cases.[5] Likewise, the capillary venous malformations found in the Sturge-Weber Demitry syndrome may also have familial backgrounds. Although incomplete manifestations may be found, it is not uncommon for this condition to affect several members in successive generations.[6] Familial, cerebral microscopic telangiectasia has been described in the hereditary Rendu-Osler-Weber disease, but in the case of the Louis-Bar's syndrome (ataxia telangiectasia) there is no solid evidence to incriminate any vascular lesion for the findings in the central nervous system. The cerebellar pathology in these cases has been related to neuronal loss and astrocytic gliosis.[7, 8]

There are numerous reports to substantiate familial sacular aneurysms and these are regarded by many to be congenital in origin.[9, 10, 11, 12, 13, 14] They are known to occur sporadically associated with the inherited disorders of connective tissue and in polycystic kidney disease.[15, 16] Occasionally, aneurysms may be associated with arteriovenous malformations in the same patient and in other members of the patient's family.[10]

Due to the extreme rarity of arteriovenous malformations, it is difficult to conclude that the cases reported here implicate hereditary rather than coincidental factors.

SUMMARY

Arteriovenous malformations occurring in sisters and presenting as subarachnoid hemorrhage have been reported. The lesions were documented angiographically and successfully managed surgically. Hereditary factors are suggested in the development of these anomalies, although the familial relationship described herein may be purely coincidental.

★★★

2500 North State Street (39216)

REFERENCES

1. Olivecrona, H. and Ladenheim, J.: Congenital Arteriovenous Aneurysms of the Carotid and Vertebral Arterial Systems, 1957, p. 5.
2. Perret, G. and Nishioka, H.: Arteriovenous Malformations, Intracranial Aneurysms and Subarachnoid Hemorrhage, 1969, pp. 200-222.
3. Tonnie, W. and Lange-Cosack, H.: Klinik, operative Behandlung and Prognose der arterio-venosen Angiome

des Gehirns and Seiner Haute, Deutsche Zeitschrift f. Nervenheilkunde, Bd. 170, S. 460-485 (1953).
4. Clark, J. V.: Familial Occurrence of Cavernous Angiomata of the Brain. J. Neurology Neurosurgery and Psychiatry 33:871-876, 1970.
5. Nicol, A. A., Mci. (1957): Lindau's Disease in Five Generations. Ann. Hum. Genet. 22:7-15.
6. Roizin, L., Gold, G., Berman, H. H. and Bonafede, V. I.: Congenital Vascular Anomalies and Syndrome (Naevus Flammeus With Angiomatosis and Encephalosis Calicificans). J. Neuropath. Exp. Neurol. 18:75-97, 1959.
7. Courville, C. B.: Encephalic Lesions in Hereditary Hemorrhagic Telangiectasis (Rendu-Osler-Weber Disease): Report of Case With the Disclosure of Microscopic Telangiectasis in the Leptomeninge. Bull. Los Angeles Neurol. Soc. 22:28-35, 1957.
8. Solitare, G. B.: Louis-Bar's Syndrome (Ataxia-Telangiectasia). Neurology 18:1180-1186, 1968.
9. Bannerman, R. M., Ingall, G. B. and Graf, C. J.: The Familial Occurrence of Intracranial Aneurysms. Neurology 20:283-292, 1970.
10. Beumont, P. J. V.: The Familial Occurrence of Berry Aneurysm, p. 399-402.
11. Graf, C. J.: Familial Intracranial Aneurysms, 304-307.
12. Kak, V. K., Gleadhill, C. A. and Bailey, I. C.: The Familial Incidence of Intracranial Aneurysms. J. Neurol, Neurosurg. Psychiat. 33:29-33, 1970.
13. Phillips, R. L.: Case Reports and Technical Notes, Familial Cerebral Aneurysms, 701-703.
14. Ullrich, D. P. and Sugar, O.: Familial Cerebral Aneurysms Including One Extracranial Internal Carotid Aneurysm. Neurology 288-294.
15. Dalgaard, O. Z.: Bilateral Polycystic Disease of the Kidneys: A Follow-Up of 284 Patients and Their Families. Acta Med. Scand. Suppl. 328:128, 1957.
16. Rubenstein, M. K. and Cohen, N. H.: Ehlers-Danlos Syndrome Associated With Multiple Intracranial Aneurysms. Neurology (Minneap.) 14:125, 1964.

"I get so lonesome," Sally complained to a friend. "If he's not fishing or bowling, he's out playing golf. He never pays any attention to me."

"When my husband pulls that, I turn on the charm," her friend said cheerfully, "and it usually keeps him home."

"I tried that. I even bought a water bed."

"Wonderful! Did he like it?"

"I guess so. He stocked it with bass."

Radiologic Seminar CXXXIX: Thyroid Scan—The "Cold" Nodule

C. D. BOUCHILLON, M.D.
Laurel, Mississippi

THE MOST COMMON reason for a thyroid radioisotope scan is to help evaluate the palpable nodule. Is it cancer or a benign process (adenoma, cyst, hemorrhage, or thyroiditis)?

Those nodules which are seen on scintigrams as rarefied or "nonfunctioning" may denote thyroid cancer and must be looked upon with suspicion. The incidence of malignancy in a single cold nodule is variably reported to be between 10 and 30 per cent. Nodules which concentrate radioactivity to the same extent as the adjacent normal thyroid tissue ("warm" nodules) are usually, but not categorically, benign. On the other hand, nodules which appear as dense or hyperfunctioning, and variously known as "toxic" adenomas, "hot" nodules or "autonomous" nodules, are almost always benign.[1]

Due to variations in anatomy and technique of scanning, lesions less than 1½ cms. may be confusing and may require a repeat scan after the use of thyroid stimulating hormone or after suppression with T-3.[2] A single cold nodule, 2 cms. or bigger, which distorts the thyroid gland has a 25 per cent chance of being malignant.[3] In one large series, all carcinomas 2 cms. or larger were visible on the scan.

It must be emphasized here that the scan, alone, should never be used as the basis for surgery. Actually, the clinical evaluation is very accurate for carcinoma. The nodule should be palpated and localized at the time of the scan, and this information correlated with the other clinical findings. Surgery of course might be indicated for reason of toxicity, or for mechanical or cosmetic complications.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jones County Community Hospital, Laurel, Miss.



Figure 1. This is the I^{131} Scintiscan of a 40-year-old female with a single palpable 2 cm. nodule in the right lobe. It was non-tender, firm, and fixed. Histology revealed it to be a benign cyst with hemorrhage and degeneration.

In summary, there is no indication for thyroid surgery, as far as possible malignancy is concerned, in any patient who has a single hot or neutral nodule that is clinically non-malignant. Certainly, however, any clinically suspicious cold nodule over 2 cms. in size should be operated. ★★★

Jones County Community Hospital (39440)

REFERENCES

1. Blahd, William H.: Nuclear Medicine, Diagnosis of Abnormal Thyroid Morphology. McGraw-Hill, 1965, p. 267.
2. Martin, Hamburger and Mellinger: The Thyroid Scintigram. Radiology 85:702, October, 1965.
3. Maynard, Douglas G.: Clinical Nuclear Medicine, Thyroid Nodules. Lea & Febiger, 1969, p. 38.
4. Jackson, Ivor and Thompson, John: British Journal of Surgery 54:1009, December, 1967.

Back Office Can Cost M.D. Precious Time and Energy

GEORGE S. CONOMIKES
Greenwich, Conn.

A PROMINENT physician once told me that he approached his back office as he approached his bedroom—reluctantly, often impulsively, and usually in the dark. One of the least examined areas of the medical practice is the activities in the back office.

Our studies of the activities, motions, patient flow, and communications patterns of many practices have shown us significant time losses, needlessly spent energy, and direct effects on productivity.

The following suggestions assume that the physician wishes to maintain a satisfactory flow of patient contacts, with as little "down" time as possible. Also, we are interested in conserving the physician's energy-effort expenditure (and that of his back-office girls).

Don't have patients waiting in back-office areas. They are seeing too much. They may expect to be able to converse with physicians or nurses. They don't like being "shuttled" from reception room to back-office waiting area to examination room. They get in the way.

Have examination rooms in a smooth flow. Don't have your consulting room in the middle of two, three, or four examination rooms. You will overuse the consulting room, or you will waste steps walking past the consulting room, which should be at one end or another of your examination rooms layout.

Try to make the examination room work. Most physicians are finding that their entire patient contact can take place in the examination room.

Don't overuse the consulting room. Patients don't expect it; it slows you down and may involve you in redundant conversation.

The biggest time-wasting flow is meeting the patient in the consulting room; then examining in the examination room; followed by a "results" session in the consulting room.

You may think the patient is getting more personal service, but in fact the patient is being made to wait for you three times rather than once.

Mr. Conomikes is president of Conomikes Associates, medical management consultants based in Greenwich, Conn. The Conomikes organization directs a series of two-day workshops on practice management and practice productivity including one sponsored by MSMA and AMA held in Jackson in December 1973. Mr. Conomikes' articles will be featured in the JOURNAL MSMA *regularly beginning with this issue.*

Don't be interrupted. One of our studies of a dermatologist's practice indicated, on the average, that each patient-physician contact was interrupted three to four times by phone calls. It's rude to the patient, and it slows you down. Most calls can be held for a call-back.

Try to make the examination room as small as possible. Save steps; be able to reach most things you require for examining the patient. Be able to have more examination rooms rather than a few large ones. Have reading matter on hand for the patients so their waiting time doesn't drag in the examination room.

Observe the 40-inch rule. Most things used most of the time in the examination room should be within 40 inches (your reach capability) of where you are usually located when working with the patient.

This means lights and light switches; instruments; dressings; gloves; depressors; towels; medications; and maybe the wash basin. Don't walk when you can reach.

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Keep cabinets within reach. Wall eabinets that hold frequently used supplies should not neeessarily be located flush to the eeiling. Sometimes they should be lowered for easier aeeess by you and your aides.

Have a minimum of three examination rooms. If you leave Room 1, and the patient in Room 2 is a "quickie," the patient in Room 1 may still be dressing or grooming. You are stopped if you don't have a third examination room with a readied patient.

Have a "battle-station." Rather than a traditional nurse's station, there eould be a working surfaee within the flow of the baek offiee, out in the open with two phones, one for the doetor and one for the nurse.

Nursing stations that are behind walls mean that you can't see her (them), and she can't easily see the physieian(s).

A good "battle-station" ean be used by the doetor, as well as the nurse, for most eall-baeks; ealls from other physicians; writing of quiek notes; hospital eontacts; quiek conferences with nurses and/or eolleagues.

Set up a communications system. It is good to have some sort of signaling device (pull-out flags, discs, lights, ete.) that indieates who's in the examination room—patient, doetor, or nurse.

Also, some sort of system, sueh as a buzzer, to call a nurse or teehnieian, is generally helpful in redueing physieian down-time.

Don't "lose" the nurse. Many doetors eomplain that their nurse is not there "when I need her."

Usually, this is related to the faet that he really has not properly integrated her into his work pattern and preferenees.

Sometimes it is due to her being unnecessarily interrupted to handle tasks (patient phone calls, hospitals, pharmaeies, labs, ete.) that could be deferred for a few minutes.

Arrange for a break-time. It may be helpful for some praetitioners to consider improving their flows by taking a break-time of about 15-20 minutes every 90 minutes.

This time would be utilized by the physician and his nurse to do their eall-baeks, ehart review, and communieation with others in the praetiee.

In this way, patient eontact time could be maximized. Less interruption would result, and a helpful ehange of pace from "hands-on" medieine is built into the busy praetiee day.

I know that the preeeding eolumn may not have helped your bedroom aetivities, but, hopefully it will increase your baek-offiee prowess. ★★★

64 Greenwich Avenue (06830)

"My dear, how niee to see you again! The last time we met, you weren't feeling well at all."

"That's right. The doetor diagnosed it as indigestion. Now, indigestion's five years old and she'll start to sehool next year."



The President Speaking

"Ruminations"

ARTHUR A. DERRICK, JR., M.D.
Durant, Mississippi

For this last offering I had planned a high-flung valediction, but here I sit facing the blankest sheet of paper I've ever seen, and not even the hint of a swan-song comes forth! Only random disconnected musings, trivial perhaps, but here they are—

First, tempus sure as hell does fugit! It hardly seems possible that a year has flown by amid the welter of meetings, trips, phone calls and correspondence—with a modicum of "catch-up" country practice in between. And two years will soon have passed since I returned home from Biloxi to stun my wife with the news that my eminent colleagues had picked me of all people for this job. I freely admit that I was pleased, proud, but puzzled. With little or no political experience or ambition and an enormous feeling of inadequacy, but with some sense of obligation to my profession, I have given it a try. But time! It is truly of the essence. There just is never quite enough.

Having reached the age where I faithfully scan the obituary column each morning, and regularly now it seems, stand in silent resignation at the grave-side of one contemporary after another, I realize that time, once so burdensome in childhood, now is at a premium. Having jousted with the grim reaper for 35 years in many a skirmish on many a field, even winning a few, it seems this familiar opponent would have lost some of his dreaded inevitability by now. I suppose what headed me down this rather morbid path is the realization that in a war of attrition replacements are most necessary, and our association needs recruits from the ranks of the stalwart young physicians among us to support our embattled profession in its effort to bring good medicine to our patients, for scouting parties are all about us, and they contain some pretty good snipers! Young clear heads will help us maintain the vigilance organized medicine must use in these odd times in which we find ourselves. ★★★

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EDITORIALS

CLOSEUP: The 1974 Legislative Session

When the 1974 Legislature adjourned sine die on April 7, 1974, it marked the end of one of MSMA's most successful legislative efforts in years. Those who doubt the assoeiation's success factor this year need only review the final record and compare the bills introduced with the bills passed. A total of 124 health or health related measures was introdueed in the 1974 Session. Of these 124 bills, only nine were ultimately passed by both houses and signed into law by the Governor. Four of these nine measures were sponsored by MSMA as a part of its four-point legislative program, and the remaining five were all supported by the assoeiation upon reeommendation of the Counеil on Legislation. Just as signifieant was the fact that all of the bills opposed by MSMA were defeated at one stage or another in the session.

As a result of the assoeiation's efforts during 1974. Mississippi will now have a Medical Examiner to investigate the eauses of all sudden or unexplained deaths; newborn infants will now be eovered from the moment of birth on all health insurance polieies written in this state, thereby eliminating the finaneially burdensome waiting periods which have plagued parents for many years; registered nurses will now have a legally reeognized expanded role in the delivery of health care; and finally, MSMA will be able to eonsult with the Commissioner of Insurance in developing a uniform elaim form for physicians services whieh will be used by all commercial underwriters of health insurance in our state, thus hopefully redueing the mountain of paper confronting the patient and his physieian.

In addition, laws were enaeted to create a State Department of Mental Health with strong professional leadership, a Division of Alcoholism and Alcohol Abuse was ereated in the State Board of Health, a new South Mississippi Center for the Mentally Retarded will be established on the Gulf Coast, the State Board of Health will begin to regulate ambulance design and equipment in addition to determining standards for the qualifieations of ambulanee attendants, and finally, physicians will be able to examine in their offiees persons who may be committed to a mental institution.

As mentioned previously, all of the bills whieh were opposed by MSMA were sueeessfully defeated at some point during the session. Three of these measures, because of their potentially deleterious effect on the health or eeonomy of Mississippi, bear mentioning. They are also worthy of note since all three will likely be introduced again during the 1975 Legislative Session.

Sen. Theodore Smith (Corinth) introdueed a measure to add ehiropraetie services to the Medieaid program. This bill was assigned to the Senate Public Health Committee where the committee members deleted the ehiropraetic provision from the bill, added some language regarding Medicaid payments to nursing homes and reported it to the full Senate. When the measure eame up for a vote in the Senate an amendment was adopted to restore the ehiropractic provision and the bill passed with only three dissenting votes. It then went to the House Public Health and Welfare Committee where it was not reported out prior to the deadline for committee reports on bills passed by the opposite house.

A second chiropractic measure was introduced by Sen. Bill Burgin (Columbus) which would have required all health insurance policies to pay for chiropractic services. It passed the Senate overwhelmingly and went to the House Insurance Committee where it was reported unfavorably to the House.

And finally, Rep. Raymond Comans (Decatur) and a host of other House members introduced a measure amending the Optometric Practice Act to allow optometrists to diagnose disorders of the eye and use pharmaceutical agents. It was assigned to the House Public Health and Welfare Committee and reported favorably to the full House only eight days later, but it died on the calendar after the deadline for acting on bills from the originating chamber had passed.

There is no doubt that the association's Legislative Contact Committee, composed of the personal physician or a physician friend of each member of the legislature, had a great deal to do with the enactment of so many significant health proposals. The personal contact by a physician to a legislator is, and will continue to be, the most successful method of influencing votes on health legislation.

Evidence of the success of such face-to-face contacts can be found in the fact that out of a total of 696 possible votes on the association's four-point legislative program, only 17 of these were in the negative.

Legislation does not become a law in a vacuum; it requires constant attention. The demands upon all governing bodies have become so great that potential laws end up competing with each other for lawmaker's attention. No bill, no proposal, no reform, is ever of such merit that it will simply weave its way through the legislative process into the Governor's hands in the absence of any voter support. A working, functioning, communicating Contact Committee did provide this necessary voice from the voters. The key axiom underlying the success or failure of any legislative program might be stated as follows: Neglect by the proponents of a bill will almost always mean its defeat, while neglect by the opponents of a measure will almost assuredly lead to its passage.

Let's hope that medicine will always have that strong, active voice.

C. D. Taylor, M.D., *Chairman*
Council on Legislation

Tetanus in Mississippi, 1951-1973

In the past 23 years, 280 cases of tetanus were reported in Mississippi. Only six cases were reported from 1970 to 1972 and no cases were reported in 1973. In both Mississippi and the entire United States, the incidence of tetanus has slowly decreased over the last 20 years. In the United States the incidence of tetanus is greatest at the extremes of age. Southern states have a higher incidence of tetanus than most other states.[1]

Tetanus will remain a potential risk for Mississippians because of the ubiquity of the organism, the lack of naturally acquired immunity, and the fact that a significant proportion of the population, particularly those over the age of 40, are not adequately immunized.

After receiving the primary immunization series, it is recommended that adults receive tetanus and diphtheria toxoids adult type (Td) every 10 years. If a dose is administered sooner as part of wound management, the next booster dose is not indicated for another 10 years. More frequent booster doses are not indicated and may be associated with increased incidence and severity of reactions.[1-2]

For tetanus prophylaxis in wound management, physicians should consult either a standard reference source or contact the Bureau of Disease Control (354-6650).



"Oh, yes, he's very patient. He's still trying to find out what Mrs. Watson came in with five years ago."

Mississippi physicians can help prevent tetanus in their patients by routinely checking the date of their adult patients' last booster of Td and by routinely questioning parents to be sure that their young children have received the recommended primary series of DPT immunizations.

D. J. Sexton, M.D.
Medical Epidemiologist
State Board of Health
Jackson, Miss.

REFERENCES

1. Center for Disease Control: Immunization Against Disease—1972. US Dept. HEW.
2. Weinstein, L.: Tetanus. NEJM 289:1293-1296, 1973.

NEW MEMBERS

Egger, Edwin G., Jackson. Born Memphis, Tenn., May 15, 1947; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned Baptist Memorial Hospital, Memphis, Tenn., 1972-73; elected by Central Medical Society.

Laws, Albert H., Jackson. Born Columbus, Miss., Oct. 10, 1941; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Emory University Hospital, Atlanta, Ga., one year; ophthalmology residency, University of Tennessee, Memphis, Tenn, July 1970-June 1973; elected by Central Medical Society.

O'Mara, William E., Carthage. Born Jackson, Miss., Dec. 8, 1945; M.D., Tulane University School of Medicine, New Orleans, La., 1971; interned University Hospital, Jackson, Miss., one year; general surgery residency, V.A. Hospital, Memphis, Tenn., July 1972-June 1973; elected by Central Medical Society.

Smith, McKamy, Jackson. Born Dallas, Tex., April 12, 1939; M.D., Baylor University College of Medicine, Houston, Tex., 1966; interned Presbyterian Hospital, San Francisco, Calif., one year; medicine residency, Ochsner Clinic, New Orleans, La., 1968-70; cardiology fellowship, University of Alabama, July 1970-June 1972; elected by Central Medical Society.

Thigpen, James Tate, Jackson. Born Columbia, Miss., June 8, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss.; fellowship in medicine, University Medical Center, Jackson, 1972-74; elected by Central Medical Society.

Wharton, George W., Jackson. Born Excelsior Springs, Mo., Feb. 14, 1940; M.D., University of Missouri School of Medicine, Columbia, Mo., 1966; interned Yale-New Haven Hospital, New Haven, Conn., one year; orthopaedic surgery residency, University of Maryland Hospital, Baltimore, Md., 1967-70; orthopaedic surgery residency, Rancho Los Amigos Hospital, Downey, Calif., Jan. 1971-Sept. 1971; elected by Central Medical Society.

DEATHS

Allred, DeWitt Talmadge, Collins. M.D., Tulane University School of Medicine, New Orleans, La., 1918; interned Charity Hospital, New Orleans, La., one year; died Mar. 12, 1974, age 83.

Howell, John B., Jr., Canton. M.D. Vanderbilt University School of Medicine, Nashville, Tenn., 1937; interned St. Mary's Group Hospital, St. Louis, Mo., one year; past president, Central Medical Society; MSMA Board of Trustees, 1956-65; past president, Mississippi Academy of General Practice; vice-speaker, House of Delegates MSMA, 1970-73; died April 3, 1974, age 63.

Owen, L. M., Vicksburg, M.D., Meharry Medical College School of Medicine, Nashville, Tenn., 1922; interned St. Louis City Hospital, St. Louis, Mo., one year; died Mar. 1974, age 75.

MSMA

106th Annual Session

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Biloxi

LETTERS

SIRS: I am currently editing a book on the personal testimonies of Christian physicians and how they view the current medical-ethical issues of today, i.e., abortion, euthanasia, organ transplants, when is a person officially dead, sterilization, psycho-surgery, semen donors, ovum donors, host mothers, reversed aging, artificial organs, genetic counseling, etc. I would like to hear from any Christian physician who would be interested in contributing to such a book or who would be able to suggest a Christian physician to write for this book. Please contact me at the following address:

CLAUDE A. FRAZIER, M.D.
4-C Doctor's Park
Asheville, N. C. 28801.

SIRS: I have compiled a listing of drugs whose names look alike and sound alike. When a pharmacist takes a prescription over the telephone or attempts to decipher a physician's handwriting, a drug product not intended by the prescriber might be dispensed. Such an error might be the result of a sound-alike or look-alike drug.

I am enclosing a partial list of such drugs with striking similarities. Physicians are urged to exercise great care when writing or telephoning prescriptions.

BENJAMIN TEPLITSY, R.PH.
1461 Shore Parkway
Brooklyn, N. Y. 11214

LOOK-ALIKE AND SOUND-ALIKE DRUGS
BY THERAPEUTIC CATEGORY

Cardiology Agents

1. Arlidin—Aralen
2. Arlidin—Aerolone
3. Cardilate—Cardalin
4. Cardilate—Calcidin
5. Isordil—Isuprel
6. Levophed—Levoprome
7. Pavabid—Paveril
8. Pavabid—Pavased
9. Peritrate—Pentrylate
10. Pronestyl—Ponstel
11. Unitensen—Salutensin
12. Unitensen—Diutensen
13. Vasal—Vosol
14. Vasal—Vontril
15. Vasal—Vastran
16. Vastran—Vesprin

Dermatology Agents

1. Alphosyl—Alphasul
2. Calamine—Calomel
3. Calamine—Coramine
4. Cordran—Cordex
5. Decadron—Percodan
6. Dermasol—Dermasul
7. Dermatrol—Dermatol
8. Elase—Alidase
9. Fostex—Phisohex
10. Garamycin—Geminimycin
11. Garamycin—Germicin
12. Garamycin—Terramycin
13. Quinolor—Quinora
14. Synalar-Synasal
15. Synalar-Synaire
16. Uval-Yuvral

Diagnostic Agents

1. Acetest—Actest
2. Clinistix—Clistanal
3. Clinitest—Citanest
4. Clinitest—Clinistix
5. Delalutin—Dilantin
6. Glucola—Glucal
7. Hematest—Hemostix
8. Hematest—Herplex
9. Histalog—Dialog
10. Ketostix—Ketosox
11. Labstix—Lasix
12. Mestinon—Mesantoin
13. Mestinon—Metatensin
14. Orinase—Orase
15. Orinase—Ornex
16. Orinase—Ornade

Endocrinology Agents

1. Cordran—Codeine
2. Cordran—Cordex
3. Decagesic—Duragesic
4. Decagesic—Equagesic
5. Decagesic—Duo-Gesic
6. Delalutin—Deladumone
7. Delalutin—Dilantin
8. Dronactin—Taractan
9. Estinyl—Esimil
10. Femogen—Femagene
11. Glukor-Glaucon
12. Haldrone—Halodrin
13. Medrol—Mebaral
14. Oreton-Oretic
15. Percorten—Percodan
16. Thyrar—Tryptar

PERSONALS

FRANK M. ACREE of Greenville was recently honored by the Washington County Medical Auxiliary for his "outstanding medical contributions." Dr. Acree was presented a plaque at the annual Doctor's Day dinner.

O. J. ANDY of Jackson and UMC presented a symposium on the implications of scientific knowledge in Racine, Wisc., Mar. 13-16.

WILLIAM O. BARNETT of Jackson and UMC served as surgeon of the day and delivered two lectures to the Lubbock Surgical Society in Lubbock, Tex.

BLAIR BATSON of Jackson and UMC attended the Easter Seal Foundation Board of Trustees meeting in Washington and the American Academy of Pediatrics Committee on Hospital Care committee meeting in Chicago.

L. H. BRANDON of Starkville announces the removal of his office to the Family Clinic, 501 Hospital Road.

ALFRED W. BRANN of Jackson and UMC spoke at the second annual perinatal medicine conference in Columbus, Ga.

H. F. CAMPBELL of Wiggins was king of the first annual Mardi Gras Ball in Wiggins.

SIDNEY A. CHEVIS of Bay St. Louis announces the relocation of his offices to 614 Dunbar Avenue.

NORMAN A. GARRISON and CARL WELCH of Corinth will begin a five-day part-time practice at Rienzi in

the branch of the Alcorn County Health Department.

THOMAS L. GRAVES has associated with the Benefield Clinic in Mississippi City for the practice of family medicine. He also joined the staff of Memorial Hospital in Gulfport.

ARMIN HAERER of Jackson and UMC served on the NIH research review panel held recently in Bethesda, Md.

VAN DYKE HAGAMAN of Jackson has retired after serving as State Ophthalmological Consultant for the Department of Public Welfare and the Division for the Blind for more than 30 years. He was presented a plaque expressing the agency's gratitude.

D. L. HOLLIS of Biloxi has been selected to membership in the Mississippi Gulf Coast Chapter of the National Football Foundation Hall of Fame. Dr. Hollis's selection to membership was based on his contributions to amateur athletics in Biloxi over a period of 40 years.

JOHN JACKSON of Jackson and UMC presented a paper at a uniformed services pediatric seminar in Biloxi.

New officers of the medical staff at St. Dominic Hospital in Jackson have begun two-year terms. They are: RICHARD JOHNSON, chief of staff; RICHARD BLOUNT, chief elect; BEN MCCARTY, secretary; W. B. THOMPSON, past chief of staff; ROSS F. BASS, chief of ob-gyn; ROBERT CROWELL, chief of family practice; EVA LINN MELOAN, chief of pediatrics; S. RAY PATE, chief of psychiatry; T. C. TURNER, chief of surgery; and C. E. WALLACE, chief of medicine.

WILLIAM A. LONG of Jackson was guest speaker at the annual convention of the Mississippi Association of Student Nurses in Biloxi.

JAMES S. MCILWAIN announces the opening of the Family Medical Center at 210 Clinton Plaza in Clinton.

NORMAN NELSON of Jackson and UMC went to the Association for Academic Health Centers meeting in Washington, D. C. in April.

GLENN BURTON RICHARDSON has joined the staff of the Memorial Hospital in Gulfport as Emergency Department Physician.

JORGE A. RODRIGUEZ of Jackson will open offices in Raleigh for the practice of surgery.

RICHARD SCHUNIOR of Picayune has been certified by the American Board of Surgery. His surgical training took place at the University of Texas Medical Branch at Galveston.

ROBERT SMITH of Jackson and UMC met with the Research Society in Richmond in March.

JAMES C. WAITES of Laurel was crowned king of the annual Magnolia Charity Ball sponsored by the Laurel Junior Auxiliary.

The Watkins, Carter, Allen Medical Group of Quitman announces the removal of their offices to 305 South Archusa Avenue.

CARL C. WELCH announces the opening of his office for the practice of family medicine at the Magnolia Doctors Plaza on Alcorn Drive in Corinth.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

May 13-17, 1974

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson
May 13-17, 1974

Sponsored by The University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

John D. Bower, M.D., associate professor of medicine and director of the Artificial Kidney Unit, The University of Mississippi School of Medicine.

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease. The management of acute kidney failure and control of reversible features of chronic kidney disease will be presented in depth. The management of pyleonephritis, fluid and electrolyte problems, and acid base balance will be covered and the participants will become familiar with hemodialysis in clinical nephrology.

POSTGRADUATE / Continued

All the intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, The Kidney Foundation of Mississippi, Inc., the Lilly Research Laboratories, the Bristol Laboratories, G. D. Searle and Company, and private donations. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

May 13-15, 1974

NEWBORN VENTILATOR COURSE
University Medical Center, Jackson
May 13-15, 1974
Sponsored by the University of Mississippi School of Medicine
Coordinator:
Jack E. Rawson, M.D., assistant professor of pediatrics, the University of Mississippi School of Medicine

This three-day course, held in the UMC Newborn Center, emphasizes treatment of respiratory problems of the newborn. Topics to be covered include intermittent mandatory ventilation, continuous positive pressure ventilation (CPPV), and acid-base calculation. Registration is open to pediatricians, nurse anesthetists, registered inhalation therapists and registered nurses who work in nurseries. A registration fee of $10.00 is charged.

FUTURE CALENDAR

May 6-9
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 13-17
NEPHROLOGY INTENSIVE COURSE

May 13-15
NEWBORN VENTILATOR COURSE

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

April 22-May 5 — *Digitalis: Friend or Foe?,* with James E. Doherty, M.D., Professor of Cardiology, University of Arkansas, and Director of Cardiology, Veterans Administration Hospital, Little Rock.

Herpes Simplex: Clues for Clinical Diagnosis, with Richard C. Gibbs, M.D., Associate Professor of Clinical Dermatology, New York University Medical Center, New York.

The Treatment of Acne, with Paul Lazar, M.D., Associate Professor of Dermatology, Northwestern University School of Medicine, Chicago.

May 6-May 19 — *Home Management of Arthritis,* with John J. Calabro, M.D., chief of rheumatology, Worcester City Hospital, and professor of medicine, University of Massachusetts Medical School, Worcester.

Sensory Feedback Therapy, a project developed by Joseph Brudny, M.D., clinical assistant professor of rehabilitation medicine, New York University, and in conjunction with members of the Bellevue Hospital Center, I.C.D. Rehabilitation and Research Center and New York University Medical Center in New York.

Zoster: A Latent Threat, with Richard C. Gibbs, M.D., professor of clinical dermatology and Philip A. Brunell, director, Laboratory of Infectious Disease, Department of Pediatrics, both of New York University Medical Center.

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change)

Book Reviews

Drugs of Choice 1974-1975. 9th Edition. Edited by Walter Modell, M.D. 832 pages with tables and drug index. St. Louis, Missouri: The C. V. Mosby Company, 1974. $23.75.

With literally thousands of drugs available to treat hundreds of diseases, and new ones being developed each day, it is necessary for the practicing physician to have some way to separate the wheat from the chaff. It has long been recognized that the best means of accomplishing this is not through the drug representative. A number of publications have been written in an attempt to provide this information, one of which is *Drugs of Choice 1974-1975*.

This book has 652 pages of text and tables, with the remaining total comprising drug and book indices. This 9th Edition is edited by Dr. Walter Modell with the assistance of 41 contributors, all being well recognized in their respective fields. The intention of this editor is for each contributor to express his own opinion concerning the drugs discussed and herein lies one problem encountered in a book such as this, as certainly there are in many instances equally good regimens that other authors might strongly support.

Even with this aforementioned limitation there are many uses for the information made available in this text. It is a quite concise reference, is well referenced for greater depth of study, is current, the drug regimens are unusually well detailed, and it serves as an excellent authoritative support. In this era when much is being said about the legal considerations of drugs and their uses it is reassuring for a physician to be utilizing a regimen supported by such an authoritative publication.

There are some criticisms to be made of the book in that some errors are apparent, such as the statement that there is no apparent cross reaction between cephalothin and penicillin and that cephalothin can be used in penicillin allergic patients. It is probable that this was a chapter in an older edition which was not changed. Some of the newer drugs were not discussed, also, meaning it will be at least two years before their true value is known.

The book, nonetheless, will no doubt be frequently used in the physician's practice as a handy reference and could be implemented as a quick reference and refresher for any of the more commonly prescribed useful drugs.

Joe M. Ross, Jr., M.D.
Vicksburg, Miss.

Chemical and Biological Aspects of Drug Dependence. Edited by S. J. Mulé, Ph.D., and Harry Brill, M.D. 561 pages with illustrations. Cleveland, Ohio: The CRC Press, 1972. $35.00.

As the editors state in the preface, this book is a reference text that provides the basic knowledge and background information that currently defines the chemical and biological basis of drug dependence and theories related to tolerance development and physical dependence. Expertise is provided through multiple authorship of outstanding contributors, 33 in all. It is divided into five basic sections and an introduction.

Part I deals with the "Significance and Characteristics of Drug Dependence." It is primarily one of various definitions and explanations of definitions of terms used in the field of drug abuse. The emphasis in this section is on the characteristics of the dependence syndrome observed in man and laboratory animals of each group of drugs and specific drugs are described as well as general characteristics in common to all.

This section ends with an excellent treatise on Cannabis Sativa by R. P. Jones including the botany, chemistry, patterns of use, effects and pharmacology.

Part II, "Criteria for Evaluating Drug Dependence," demonstrates fully the signs and symptoms of physical dependency and withdrawal syndromes of the various drugs of abuse. It must be remembered that when the authority in this section states that a particular substance does not exhibit any significant dependence, he is referring to physical dependency. The same substance may, in fact, have a strong psychological dependence. Methods are described that will help the reader in predicting the

abuse potential of particular drugs. This can be of much clinical benefit.

Part III, "Chemical Aspects of Drug Dependence," is an excellent section both as a review and reference work on the chemistry and metabolism of drugs of abuse. This section comprises over one half of the entire volume. It is very detailed and presents the subject matter in such a way that the need for referring to other publications on this particular subject will generally not be needed. Structural activity correlations are presented in an orderly fashion. The chapter by S. Stalman describes the physicochemical properties, synthesis and structure-activity relationships of the barbiturates, the 1,3-propanodiols and the benzodiazepines.

The pathogenesis of the effects of ethanol in lipids, drugs and intermediary metabolism is discussed. Understanding these effects enables the reader to more fully understand the development of most of the pathological conditions resulting from ethanol abuse and will assist the clinician in his treatment of these conditions. The interaction of drugs of abuse with a number of different neuronal components is discussed in detail.

A. P. L. Misra in his chapter discusses the disposition and metabolism of drugs of dependence. Included in this chapter are the absorption, distribution, fate and excretion of drugs in the body as well as chemical properties and dosages. This section ends with detection and identification of dependent drugs. It includes both qualitative and quantitative tests utilizing microcystalic, physicochemical, ultraviolet, infrared spectroscopy, chromatography and many other methods. Emphasis is placed on detection in biological materials which require extraction of the drug and metabolites prior to analysis.

Part IV, "Physiologic and Pharmacologic Aspects of Drug Dependence," begins with the detailed description of the phenomenon of tolerance. Most books on drug abuse gloss over this very important aspect of the substances of abuse. The reader is taken step by step through the basic mechanism of tolerance in a concise, easily understood and orderly fashion, and then into the tolerance of specific groups such as narcotic analgesics, depressants, stimulants, psychotomimetics, and cannabis preparations. The absorption metabolism, excretion and distribution are discussed as well as cellular and homeostatic mechanisms. The second part of this section is an explanation of theories related to physical dependence by A. Wikler.

The electrophysiology and neuropathology of drugs of dependence are also observed in this section. The section ends with teratogenicity, embryolethality, and mutagenicity of drugs of dependence. The authors pointedly note that many more studies are needed in the above aspects of drugs of dependence before we can come to some valid conclusions.

Part V, appropriately entitled "Biochemical Aspects of Drug Dependence," begins by describing the relationship of the mechanism of drug action through enzyme inhibitions by S. T. Christian. It summarizes the effects of narcotic analgesics, psychotomimetics, barbituates and stimulants on isolated enzymes and enzyme systems. This section demonstrates that various enzymes are affected by the drugs described and emphasizes the importance of understanding the role they play in the mechanisms of action of drugs including physical and/or psychic dependence.

Then follows discussions of studies of protein and nucleic acids generally and their relationships with drugs of abuse; the carbohydrate metabolic relationship to narcotics, barbiturates, alcohol, amphetamines, hallucinogens, cocaine and related drugs; neurotransmitters and the narcotic analgesics; a review of studies of interactions of cellular lipids of drugs of dependence; and a chapter on hormones which demonstrates changes in endocrine activity as a result of the actions of drugs of dependence.

The book ends with consideration of theoretical and biochemical mechanisms for drug dependence and examines mechanisms in tissues other than the central nervous system as well as mechanisms in the central nervous system.

I found this book to be an excellent reference text for chemical and biological aspects of drug dependence—exactly as titled. It covers that area exceptionally well, but it is important to remember that psychological dependence is a completely different aspect of drug dependence and, therefore, has little part in this book. Some drugs of abuse will have only psychological dependence and their absence from this text does not infer lack of drug dependency. Although the text is a reference book sufficient for most needs, there are over 150 pages of references for further study for those interested.

All in all, because of the detailed specific nature of this book, the length and the cost, I would recommend this book primarily as a very excellent reference book, for libraries and for drug treatment and rehabilitation centers.

John F. Russell, M.D.
Gulfport, Miss.

Medico-Legal Briefs

VIEWPOINT OF A PLAINTIFF'S ATTORNEY

By J. B. Spence, partner, Spence, Payne & Masington, P.A., Miami, Florida. Mr. Spence is chairman of the American Trial Lawyers Association's Malpractice Committee and a former member of the A.T.L.A. governing board. He has served as president of the University of Miami Law School, member of the Miami Law Quarterly and Florida Assistant Attorney General.

As an attorney who specializes in medical malpractice litigation, I have formed opinions which I have had occasion to present to the staffs of hospitals, medical conventions, and other interested groups.

I am offered two or three malpractice cases every day. This tells me that there is a substantial loss of rapport between the medical community and its patients.

Why are so many patients going to lawyers?

Why are so many malpractice cases being filed?

Why are so many malpractice cases being tried?

Why are juries frequently returning verdicts in excess of $1 million in medical malpractice cases in the U. S.?

The answers, in my opinion, have to do with the thinking of the medical community, the companies which write medical malpractice insurance and the defense lawyers who represent these insurance companies.

No one thinks settlement. The insurance attorney makes a substantial fee defending the case. Frequently, his motivation is to advise the doctor or the hospital that the defendant has a substantial chance to win the case. The doctor wants to hear this; so does the hospital administrator. The defendant always seems to want to justify what he did. Anger over being sued often clouds individual judgment.

For decades in America the plaintiff virtually could not win a medical malpractice case. The law was totally and completely in favor of the hospitals and the doctors. Rigid, protective laws existed, nationwide, to isolate and immunize the medical community. This was wrong, unjust and unfair. The law is often slow to change or adjust, but in this type of litigation the legal pendulum is moving. The law in most states now comes close to being fair to both sides in a case.

This has occurred because plaintiffs' lawyers across America almost in unison decided to fight back. Cases were taken and tried, and old rules have changed. The protective circle of immunization largely has been swept aside; justifiably, in my opinion.

Our position is thus: If you run a stop sign and it's your fault and you hurt someone, why should you get up tight about paying for it? Or, if you are medically careless and run a medical stop sign, why should you not pay for it?

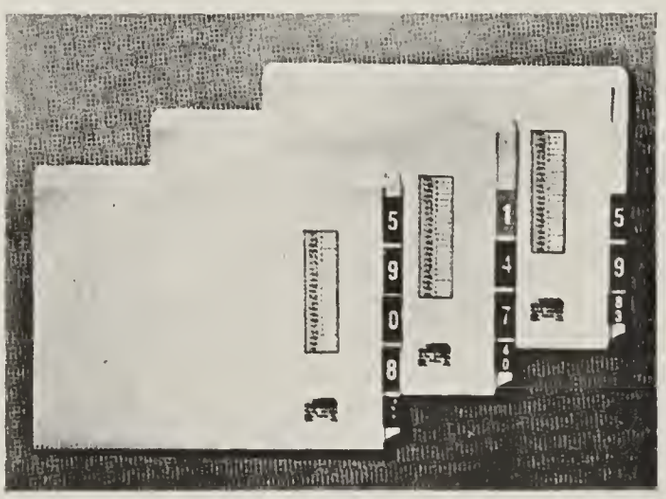
If the medical community refuses to negotiate and settle by being lulled into a feeling of self-righteousness by defense attorneys, we are going to continue to have the world of malpractice litigation in which we presently live.

Jurors no longer are as sympathetic with doctors and hospitals. Jurors now come to the jury box with some prejudice about waiting in a doctor's office for two hours before being seen; about being ignored while urgently ringing the bell in the hospital to get a nurse's attention; about being overcharged; about being treated like cattle. Simply put, the chickens are coming home to roost.

Kind, gentle care; punctuality, human understanding, a real "visit" with the doctor, are among the hundreds of thoughtful ways to re-establish rapport between patients and the medical community and to wipe out a substantial percentage of malpractice allegations and claims.—(Reprinted from *Malpractice Digest,* March-April, 1974.)

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Introducing: The State Health Officer

Dr. Alton B. Cobb, who took the helm last year as State Health Officer, sees the number one goal of the State Board of Health to be improving the delivery of health services at the local level.

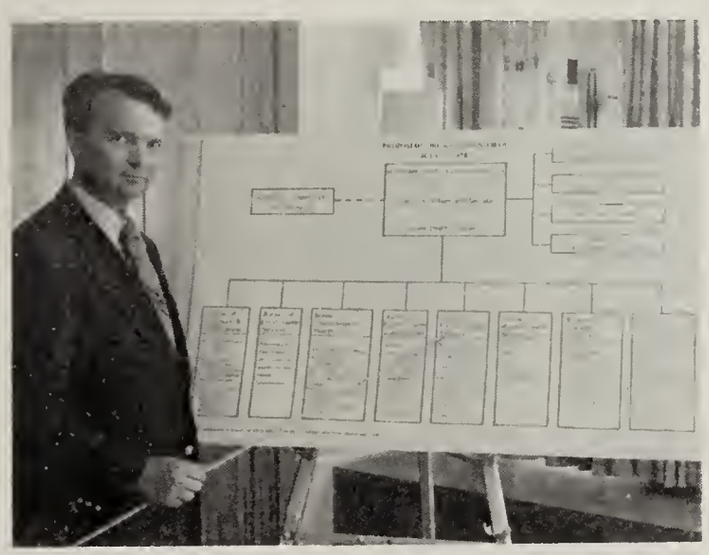
To implement action in reaching this goal, Dr. Cobb has initiated a reorganization plan that, upon implementation, will decentralize the delivery of services stemming from the current office in Jackson.

The plan will organize services on a district level rather than the present central office/county health center working relationship. Personnel will be assigned to each district to formulate and plan public health programs, consult with, and support local personnel in county health centers.

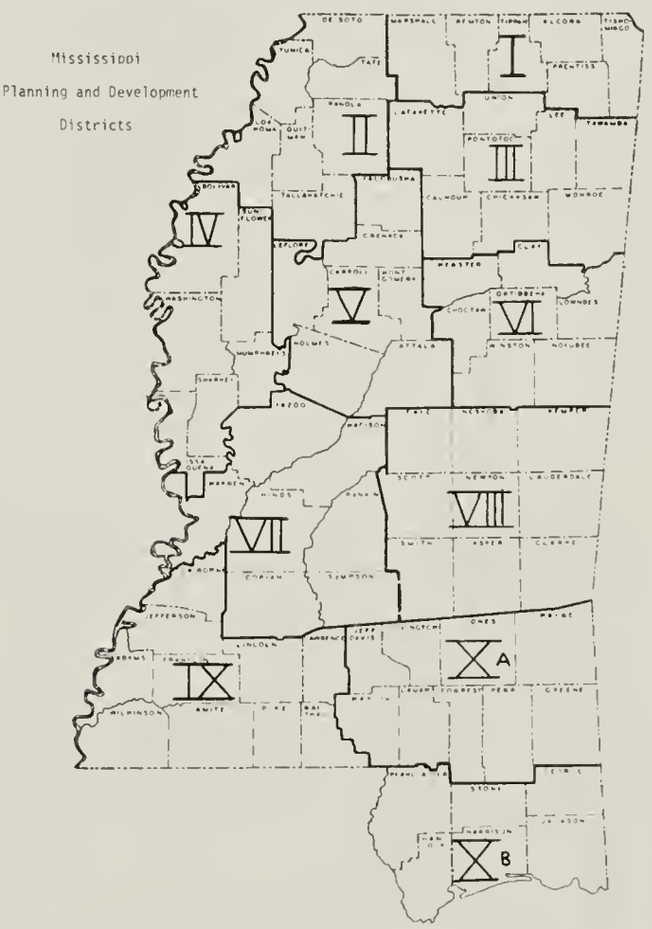
There will be 11 districts in the state and boundaries will be essentially the same as the planning and development districts used by Comprehensive Health Planning.

The 1974 state legislature approved funding to initiate seven of the districts during the 1974-75 fiscal year.

Dr. Cobb emphasized that the utilization of specially trained personnel on the district level will in turn mean increased and more efficient delivery of higher quality services to all Mississippians.



Dr. Cobb looks over the proposed reorganization chart for the State Board of Health.



He indicated that one approach to expanding available services is the training of nurses to do more things under medical supervision to extend more health services to the people. There are 8 trained family planning nurse practitioners currently working in health departments. Additional public health nurses now are being trained as pediatric nurse practitioners and family planning nurse practitioners.

ORGANIZATION / Continued

In his first year as head of the state agency, Dr. Cobb has also concentrated his efforts on planning and completing the reorganization of the central division and units into more functional groupings that are more responsive to need.

There are 13 major divisions exerting various degrees of supervision over 32 separate programs and offices and 81 county health departments. Plans now call for grouping various units into seven broad-based bureaus.

The seven bureaus will be Licensure and Certification, Local Health Services, Environmental Health, Public Health Laboratories, Family Health Services, Disease Control and Administrative Services.

Mental Health Services, long an integral branch of the State Board of Health, will be transferred this year to the State Board of Mental Health as a result of legislative action.

In regard to the 1974 legislative session, Dr. Cobb reported that there were several major legislative measures in the area of public health. A solid waste bill gives the SBH authority to establish standards and supervision. The Emergency Medical Services Act gives authority to establish standards for ambulances, attendants, and equipment. The Uniform Alcoholism Act decriminalizes alcoholism and brings it into the medical area while also providing for the establishment of alcoholism treatment centers.

Other legislation provides funds to expand the Crippled Children's Service, the cystic fibrosis program and the public health dentistry program. Funds were also approved for the implementation of a new program for the care of hemophiliacs.

Dr. Cobb indicated that the State Board of Health will continue its vital efforts in VD and TB identification and treatment, maternal and child health care, communicable disease control, hypertension, cervical cancer screening and the environmental health program.

He expressed appreciation to the State Board for its interest and support. The Board consists of Drs. Benton M. Hilbun of Tupelo; G. Lacey Biles of Sumner; John G. Egger of Drew; S. Lamar Bailey of Kosciusko; Lamar Arrington of Meridian; J. G. McKinnon of Hattiesburg; W. Moncure Dabney of Crystal Springs; and Wilfred Q. Cole of Jackson.

Also on the Board from the state-at-large are Felix K. West, D.D.S., of Clarksdale; Eric Muir, O.D., of Cleveland; John E. Gore, Jr., R.Ph. of Clinton; and Dr. Cobb.

By virtue of being State Health Officer, Dr. Cobb is an Ex-Officio member of 12 other agencies including Mississippi Commission on Hospital Care, Advisory Council of Mississippi Medicaid Commission, Mississippi Board of Nursing, Comprehensive Health Planning State Advisory Council and Mississippi Interagency Commission on Mental Illness and Mental Retardation.

The State Health Officer came to the Board of Health position July 1, 1973, from the Mississippi Medicaid Commission where he served as Director since 1969.

Dr. Cobb earned his M.D. degree from Johns Hopkins School of Medicine in 1954 and completed internship at Charity Hospital in New Orleans. He received the M.P.H. from Tulane University in 1960 and served a Public Health residency at the Mississippi State Board of Health. He is a Diplomate of the American Board of Preventive Medicine.

MHA Proclaims May Hypertension Month

Dr. Norman C. Nelson, vice chancellor for health affairs and dean of the medical school at the University of Mississippi Medical Center, will serve as chairman of a committee to organize High Blood Pressure Month in Mississippi during May, according to Aven Whittington, president of the Mississippi Heart Association.

Others on the committee are Dr. J. P. Tatum, practicing internist, of Meridian; Dr. Walter Washington, president of Alcorn A&M College, Whittington; Dr. Allen W. Cowley, associate professor, department of physiology and biophysics, University Medical Center; and Dr. Herbert Langford, professor, department of medicine and director of the Clinical Research Center, University Medical Center.

Dr. Tatum is a former American Heart Association vice-president, a board member of the Mississippi Heart Association, and currently chairman of its High Blood Pressure Advisory Committee; Dr. Washington is a board member of the Mississippi Heart Association; Dr. Cowley is an American Heart Association established research investigator and Dr. Langford is a member of the AHA Council on High Blood Pressure Research.

Whittington said the Mississippi program is part of a nationwide educational effort throughout the month of May to attempt to reduce the toll of death and disability resulting from hypertension. "We are attempting to focus statewide attention on the neces-

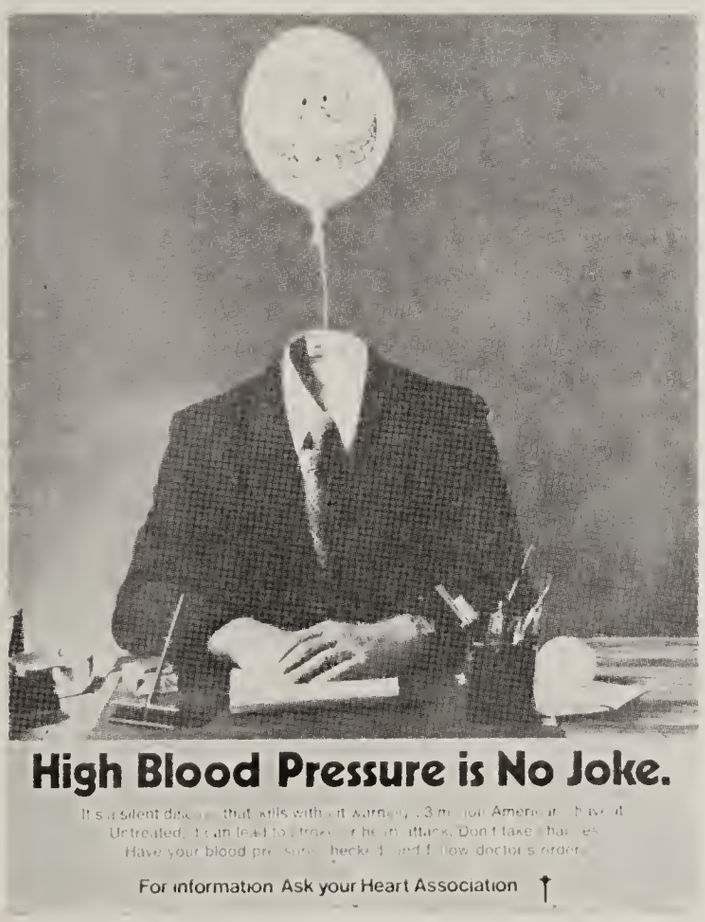
sity of controlling high blood pressure," he added.

Whittington noted other sponsoring organizations for National High Blood Pressure Month are the American Medical Association, Citizens for the Treatment of High Blood Pressure, National Medical Association, and the U. S. Department of Health, Education and Welfare. There are also more than 70 endorsing organizations, including the Mississippi State Board of Health. All these individual efforts will be coordinated through the American Heart Association.

Dr. Nelson said his committee has prepared numerous plans to increase awareness of the dangers of high blood pressure during May and to encourage the public to have a blood pressure measurement. "There are approximately 300,000 Mississippians with hypertension and about half of them don't know they have it," he emphasized. "This is because there are no easily discernible symptoms until a patient suffers a stroke or heart attack."

Dr. Nelson emphasized the May campaign will serve to draw attention to existing high blood pressure programs, and also to start programs where none previously existed. "We want to make it clear that emphasis on the detection and control of high blood pressure will continue long after May has passed," he noted.

He said a recent research survey showed that treating people with mild blood pressure, previously overlooked, can dramatically reduce the risk of major complications.



Shown is the poster which will be used extensively in publicizing High Blood Pressure Month.

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MSMA-MFMC Boards Hold Spring Meeting

The Mississippi State Medical Association Board of Trustees and Mississippi Foundation for Medical Care Board of Directors conducted their final meetings prior to the MSMA annual session in Jackson on Mar. 28-29, 1974.

Primary items of business coming before the MSMA Board were the annual association audit and reports to the House of Delegates from the Ad Hoc Committee to Study Realignment of Association Districts, Council on Legislation, Council on Scientific Assembly, and Committee on Publications.

The association's annual audit and budget will be the basis of a recommended dues increase from the Board and Council on Budget and Finance to be presented at the May annual session.

The report of the Ad Hoc Committee to Study Realignment of Association Districts results from actions by the House of Delegates at the 1973 annual session which established a committee to study and recommend changes in the composition and tenure of office of the Board of Trustees and the numerical equality of association districts. The Board directed that the report be sent to all delegates to the 1974 annual session.

Reports from the Council on Legislation, Council on Scientific Assembly, and Committee on Publications dealt with the 1974 Regular Session of the Mississippi Legislature, planning for the annual session, and a report on operations of the JOURNAL MSMA respectively. The Board commended the Council on Legislation for one of the association's most successful legislative programs in recent years. Plans for the annual session as reported by the Council on Scientific Assembly include such new activities as an Association Membership Breakfast, a Woman's Auxiliary sponsored welcoming committee to greet all members, and a poolside Association Fellowship Party. The Committee on Publications reported on successful completion of the 13th year of operation of the JOURNAL MSMA and the Board commended the Committee on Publications, editors, and staff in this regard.

Meeting in conjunction with the MSMA Board of Trustees, the Mississippi Foundation for Medical Care Board of Directors considered extensive reports covering the subjects of PSRO, EMCRO, professional fees, and membership.

The foundation's subcommittee on PSRO planning presented a "PSRO Implementation Plan for Mississippi" and the Board directed that the "Plan" be presented for review at the MFMC membership meeting to be conducted during the annual session on Thursday afternoon, May 9. The Board additionally received a status report on the Mississippi EMCRO Program which has been funded for its fourth year of operation beginning June 1, 1974.

The foundation's Committee on Fees reported on its survey of physician fees in Mississippi which is nearing completion and the Board directed that a full report on the fee survey be given at the MFMC membership meeting. The Board additionally accepted 14 new members bringing the total MFMC membership to 947 Mississippi physicians.

Former Surgeon General Visits Medical Center



Dr. Luther Terry, left, visited University of Mississippi Medical Center last month and talked with Dr. Carl G. Evers, associate dean for student affairs, and other staff members while in Jackson for the Hinds County Chapter American Cancer Society crusade kick-off dinner. On leave of absence from the University of Pennsylvania, the noted physician is serving as president of University Associates, Inc., of Washington, D. C., and is a special consultant on tobacco and cancer to the American Cancer Society. Dr. Terry served as U. S. surgeon general during the administration of President John F. Kennedy.

Ole Miss Alums Begin Externship Program

The Ole Miss Medical Alumni Chapter has launched a new project called the "Externship Program," according to Dr. William E. Bowlus, chairman of the Alumni and Students Together Committee.

The committee is encouraging physicians in Mississippi to invite students to their communities during the period between their junior and senior years in medical school for a learning/earning situation. The physician and student would work out an agreement whereby the student would come to the physician's community for work in his medical environ-

ment for a period of time of their mutual choosing.

The project is designed to help the student determine what the private practice of medicine is really all about and to provide some financial assistance for his own support. The physician would benefit from interaction with the student in a teaching situation.

One of the basic propositions of this program is to encourage more young physicians to stay in Mississippi to pursue their professional undertaking, said Dr. Bowlus. Physicians in any specialty are invited to participate.

For more information contact Dr. Bowlus or Mr. Bill Price at the Ole Miss Medical Alumni House, 2500 North State Street, Jackson 39216.

Delta Medical Society Holds April Meeting

The Delta Medical Society held its 101st semi-annual meeting at 2:00 p.m. on April 10 in Greenville at the Mississippi Power and Light Co. building. The meeting was preceded by a Board of Governors Luncheon.

Dr. John Suares of Greenville gave the address of welcome which was followed by a scientific session. First on the program was Dr. Joseph A. D-Ercole of Stoneville who discussed "An Epidemiology Study of the Effect of Pesticides on Newborns."

Next Dr. Ben B. Rader of Indianola spoke on "Emergency Medicine: Friend or Foe." Dr. Donald Sherline of the University Medical Center in Jackson explained "Fetal Maturity and Fetal Monitoring in the Diabetic Pregnancy."

Final guest scientific speaker was Dr. Howard A. Nelson, Jr., of New Orleans who discussed "Ruptured Ectopic Pregnancy Following Vaginal Hysterectomy."



Dr. Arthur A. Derrick, Jr. of Durant, MSMA president, at left, discusses medical politics with Congressman David Bowen.



Dr. Howard A. Nelson of Greenwood was presented a framed resolution commending his many years of dedicated service at the Delta Medical Society meeting in April. From left are Dr. Walter Rose, society secretary; Mrs. Nelson; Dr. Nelson; and Dr. Derrick.

A special feature of the meeting was an address by the Honorable David E. Bowen, U. S. Congressman from Mississippi, on "The Future of Medicine in the Political Arena."

During the business session, a framed resolution of commendation was presented to Dr. Howard A. Nelson of Greenwood in honor of his many dedicated years of service to medicine and to his community and state.



Dr. Stacy Davidson of Cleveland, president of the Delta Medical Society, is shown addressing the group at its 101st semi-annual meeting.

Dr. Arthur A. Derrick, Jr., of Durant, president of MSMA, also addressed the society.

Officers are Dr. L. Stacy Davidson of Cleveland, president; Dr. Robert N. Hurt of Indianola, president-elect; and Dr. Walter H. Rose of Indianola, secretary-treasurer. County vice presidents are Drs. Arthur Lindsey, Bolivar; Thomas J. Barkley, Humphreys; Fred Sandifer, Jr., Leflore; Virginia Tolbert, Sunflower; and John C. Suares, Washington.

Serving as Trustee to the MSMA from District 1 is Dr. Lyne S. Gamble of Greenville.

State Public Health Physicians Recognized

The Mississippi Association of Public Health Physicians has been accepted as a recognized chapter of the American Association of Public Health Physicians, Dr. William Riecken, state chapter president, said.

Dr. Riecken, assistant director of local health services for the State Board of Health, indicated that the state organization received notification of the national recognition at the national winter meeting.

The state organization itself was formed last year and has a membership currently of 20. Dr. Alfio Rausa of Greenwood is vice-president and Dr. Eric McVey, the secretary-treasurer, is from Jackson.

National Guard Now Evacuates Patients



A National Guard helicopter flight to University of Mississippi Medical Center in late March meant life-or-death for five-day-old Jerry Wright, Jr., of Meridian.

A UH1 helicopter made the flight, one of the first transports under a new cooperative agreement between the National Guard and UMC. The UH1, designed especially for transporting patients and used extensively for that in Viet Nam, brought the baby to Jackson for the medical care he needed.

UMC staff found that the baby had two threats to his life: esophageal atresia and tracheal esophageal fistula. Although the UMC newborn center usually treats five to seven similar cases each year, his was the fourth since January.

Trained in air evacuation, the National Guard has the potential of helping many Mississippians, Dr. Alfred Brann, newborn center director, said.

Governor Proclaims Medical Assistant Week



Looking over the proclamation declaring the week of Mar. 24-30 to be Medical Assistant Week in Mississippi are (left to right) Mrs. Gladys Lamb, president-elect of the American Association of Medical Assistants, Mississippi Society, Governor William Waller, and Mrs. Helen Donohoo, state president. Delta Chapter, AAMA, MS, was hostess for the annual state convention in Greenwood Mar. 29-31.

UMC Ob-Gyn Faculty Speaks in State

Obstetrics and gynecology faculty from the University Medical Center are traveling Mississippi as visiting professors from February through June.

Dr. Donald Sherline, associate chairman of the obstetric-gynecology department, led off the program at Oktibbeha County Hospital in Starkville Feb. 20, with Dr. Len Brandon as local arrangements chairman. Other teams traveled to Tupelo in March and to Greenwood in April.

Local coordinators choose a program from 13 subjects such as prenatal care, the high risk patient, diabetes in pregnancy, abnormal labor, family planning counseling, and resuscitation of the newborn.

The meetings are open to all health professionals in the field of maternal-child health. Participating physicians receive six hours of continuing education credit from the American Academy of Family Practice.

The program is supported by the Maternal and Child Health Service (HEW) through a grant to the American College of Obstetricians and Gynecologists. Sponsors are the University Medical Center obstetric-gynecology and family medicine departments.

New National Blood Program Established

The American Medical Association, American Association of Blood Banks, Red Cross, and Council of Community Blood Centers have joined together to establish an American Blood Commission that will seek to assure a national, all-volunteer supply of blood for transfusions and medical emergencies by Dec. 31, 1975.

The proposed plan is for a volunteer program controlled at the local level, with medical societies playing a major role. Some 150 national groups with an interest in a safe blood supply would be members of a commission that would oversee each regional program. The regional programs in turn would guide the activities of blood banks and transfusion facilities in their own area.

Last fall the Administration warned that if the private sector could not reach agreement on a national program, a federally mandated program would be sought from the Congress.

The major difference had pitted a for-profit against non-profit blood supply. In the non-profit field, the American Association of Blood Banks (AABB) and the American National Red Cross have vied for the leadership role. The non-profit blood banks—largely hospital units—chiefly have favored a non-replacement fee for blood as the most dramatic way of attracting donors, whereas the Red Cross traditionally has relied on strictly volunteer blood.

Under the proposed plan, the for-profits would be out in the cold. The hope is that with better coordination, exchange, and inventory through a regional system, a non-replacement fee system will not be needed though it would be permitted.

The plan has been published in the Federal Register in order to give interested groups time to comment. At a later date HEW will sponsor a conference to consider comments and decide a course of action.

Exorcising the Anti-PSRO Devils

One of the American Medical Association's latest public relations efforts—an information kit titled "PSRO—Deleterious Effects"—was criticized by HEW Assistant Secretary for Health, Charles C. Edwards, M.D., and Senator Wallace F. Bennett (R-Utah), sponsor of the Professional Standards Review Organization law.

The kit, which contains speeches, suggested editorials, and other material attacking the PSRO program, was distributed nationally to physicians and medical societies. Its main speech is entitled "Exorcising the Devil from PSRO."

In a telegram to AMA Executive Vice President, Dr. Ernest B. Howard, Bennett accused the AMA of achieving "new heights of distortion and misrepresentation" and said the kit exposed "the most non-professional and least credible aspects of the AMA." Edwards, who also sent Howard a telegram, described the kit as "not only factually incorrect, but also incomplete and misleading in its overall presentation."

Bennett reminded the AMA that the PSRO law—part of PL 92-603—was patterned after the AMA's PRO proposal. It requires that local practicing physicians form peer review organizations to oversee the quality of care provided in institutions to Medicare and Medicaid patients and to patients being cared for under federally supported Maternal and Child Health programs. He stated: "In fact, as you know, the PSRO legislation was modified to accommodate your formal recommendations in all save one respect—that is to entrust the PSRO responsibilities to the State Medical Societies," which Bennett said was impossible in a public program.

He said he is looking forward to discussing the AMA's effort "to deny local practicing physicians that chance" during the Senate Finance Committee hearings on PSRO scheduled May 8-9.

Edwards, pointing to the recognized problems in the quality of medical care, said that many physicians and the public "know very little about the PSRO law" and that the government and organized medicine should be trying to increase understanding and "not aggravate the situation through misinformation."

In answering the AMA's allegations on the Senate floor, Bennett said "the allegations, distortions, half-truths, misrepresentations and downright hypocrisy which have characterized an almost unparalleled campaign against the professional standards review program" have been part of a campaign conducted by three organizations.

These three, he said, "each representing and apparently speaking in behalf of overlapping segments of medicine," are the Council of Medical Staffs, the American Association of Physicians and Surgeons, and the AMA. Fortunately, Bennett said, they do not speak for all doctors.

Bennett's answer to AMA allegations—printed in the April 2 *Congressional Record*—is called "Exorcising the Anti-PSRO Devils."

Health May Be A Public Utility

The American Medical Association has warned Congress that legislation before it would treat the health sector as "one vast, monolithic public utility" with the Secretary of Health, Education, and Welfare "a health care czar."

Testifying before the Senate health subcommittee on a bill (S2994) sponsored by Senator Edward Kennedy (D-Mass.), AMA President Russell B. Roth termed the bill "one of the gravest steps to be proposed concerning health care delivery." The measure calls for replacement of Comprehensive Health Planning and Regional Medical Programs by a formal planning system coupled with public utility regulations by state health commissions under HEW supervision. "We are opposed to the creation of public utility type regulatory controls and the planning mechanisms in this and similar measures," Dr. Roth said.

The bill before the Senate health subcommittee calls for a formal system of planning coupled with public utility regulation by state health commissions under the supervision of the HEW department. It is part of a comprehensive measure extending certain public health service programs and making sweeping changes in the nature of the present Comprehensive Health Planning and Regional Medical Programs. Similar bills have been introduced in the House of Representatives.

"In our view, this extreme measure is unwarranted, with justification based on either experience or need. It carries serious potential for impeding a beneficial development of medical care," Dr. Roth said.

He termed the bill an "unprecedented federal involvement in matters which, under our federal system, have traditionally resided in state and local governments.

"We must caution against the imposition of a massive bureaucratic control of the health care system. The expertise within governmental bureaucracy must be questioned. We cannot afford to institute a system which can stifle meaningful competition, innovation, and development of appropriate health care services and facilities. The economic forces inherent in this proposal could defeat the intention of this committee to foster the developments of improvements in our health care delivery system."

A major provision of the legislation would require the state health commissions "to determine prospectively rates used for reimbursement purposes for health services of health care providers within the state and regulate all reimbursements of such health care providers made on either a charge, cost, negotiated, or other basis and review such rates at least once a year."

All of the authority ostensibly vested in the state bodies can ultimately rest in the HEW Secretary, Dr. Roth noted. He asked whether this means the federal government could:

- close down private health care institutions and even federal facilities?
- shut a municipal or state hospital?
- regulate salaries, wages, collective bargaining agreements of health care workers?

"Is the performance of the Secretary of HEW and the Administration so exemplary and so unquestionable that they should be the ultimate repository of the total authority over the entire health care delivery system?" Dr. Roth asked.

The strengths of the present system which have developed in the absence of structured planning should not be overlooked, testified Dr. Roth.

"In our view the contemplated formal system of planning coupled with the public utility regulation cannot be justified," Dr. Roth said. "Nor should the extreme governmentally mandated system of planning and regulation be adopted without evidence that such a plan can reasonably be expected to succeed. We believe it is prudent to proceed on an experimental basis so as to determine what mix of voluntary planning together with governmentally required planning proves to be the most effective in specific regions of this country."

Four County Health Centers Are Funded

The Commission on Hospital Care has approved some $550,000 federal Hill-Burton funds for construction of four county health centers in the state.

The $1.1 million construction program, with approximately $600,000 coming from local and Appalachian Regional Commission funds, will place new health centers in Ashland, Benton County; Macon, Noxubee County; DeKalb, Kemper County; and Hattiesburg, Forrest County.

According to Dr. Alton B. Cobb, State Health Officer, the three centers in Ashland, Dekalb, and Macon will be funded 50% by Hill-Burton, 30%

by the ARC, and the remaining 20% in local funds.

The new health facility in Hattiesburg will be funded jointly with Hill-Burton and local funds. All counties have agreed to furnish the sites for the new facilities.

The center at Ashland will contain some 3,400 sq. ft.; Macon, 3,500 sq. ft.; Dekalb, 3,300 sq. ft.; and Hattiesburg, between 10,000 and 12,000 sq. ft.

The agency is developing plans to use temporary or portable facilities for clinic buildings in the smaller communities of the state.

He noted that he expects the Ashland, Dekalb, and Macon projects to be under contract before July 1 with the projected completion date in January, 1975.

Dr. Petersdorf Is Visiting AOA Professor



Dr. Robert G. Petersdorf, center, and University Medical Center senior medical students Tom Brewer of Leland, left, and Dick Smith of Clinton discuss what every young doctor should know, Petersdorf's topic for Center Assembly there last month. The chairman of the Department of Medicine, University of Washington School of Medicine, Seattle, lectured and met informally with students and doctors while in Jackson Mar. 25-30 as Alpha Omega Alpha visiting professor.

Cholera Vaccination Requirements Changed

Last year, 70 countries had some type of cholera vaccination requirement for travelers. Effective Jan. 1, 1974, the International Health Regulations were modified by the Twenty-sixth World Health Assembly of the World Health Organization to eliminate the requirement for cholera vaccination for international travelers. All countries except 20 have indicated compliance. These countries may be classified as follows:

I. Countries that continue to require evidence of cholera vaccination from travelers arriving from cholera-infected areas or from all countries any parts of which are infected: Australia, Christmas Island, Egypt, Greece, Guinea, Iraq, Libyan Arab Republic, Madagascar, Malta, Namibia, Nauru, Saudi Arabia, Swaziland, Thailand, Yugoslavia.

II. Iran requires evidence of cholera vaccination from travelers arriving from cholera-infected areas and from Afganistan, Bahrain, Bulgaria, Burma, India, Iraq, Malawi, Malaysia, Pakistan, Philippines, Singapore, Thailand, Tunisia, Vietnam. Italy requires evidence of cholera vaccination from travelers arriving from all countries any parts of which are infected and from Guinea.

III. Papua-New Guinea requires evidence of cholera vaccination from all travelers except those coming from Oceania.

IV. Burma and India require evidence of cholera vaccination from all travelers departing for any country which requires cholera vaccination certification.

(Reported by the Bacterial Diseases Branch and the Quarantine Branch, Bureau of Epidemiology, CDC, MMWR 23:2, 1-12-74.)

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Kennedy-Mills Introduce Health Insurance Act

Congressman Wilbur D. Mills (D-Ark.) and Senator Edward M. Kennedy (D-Mass.) have jointly introduced a Comprehensive National Health Insurance Act of 1974 (H. R. 13870, S. 3286).

The NHI proposal is similar to the Administration's proposal and represents a withdrawal from the position previously stated in S. 3, the Kennedy-labor sponsored Health Security Act. The new bill provides for inpatient hospital services with no day or dollar limitation, physician services, and other medical services subject to an annual deductible of $150 and 25 per cent coinsurance. The deductibles, however, would not apply to certain items such as prenatal care, well baby care, and dental care for children. The maximum deductible per family would be $1,000 per year as opposed to $1,500 under the Administration plan.

The Kennedy-Mills bill would be mandatory, requiring participation and contribution from all persons. Practitioners would be free to participate in the program, but if they choose not to, they could not provide services under the system. A community-rated premium would be determined nationally, and employers would be required to contribute 3 per cent of payroll up to an earning level of $20,000. Employees would contribute 1 per cent of earnings up to $20,000. Premiums would be collected through the Social Security system, and a new Social Security Board, reporting directly to the President, would direct the program. Existing health insurance carriers would be retained to collect coinsurance and deductibles, make disbursements, and administer the transaction of insurance claims.

The sponsors of the legislation further anticipate that private carriers would continue to write insurance policies covering supplemental benefits. The bill also adopts the Administration's plan for a health credit card so that patients would be billed for coinsurance and deductibles after receiving care.

The legislation would also establish a National Health Development Resources Board within HEW to be responsible for the delivery of health care services provided under the measure. Additional provision is made for prospective budgeting of institutional providers. All services reimbursed by the program would be subject to PSRO review within two years of the effective date for payment of benefits.

Diagnostic X-Ray Standard Workshops Set

A Federal standard for diagnostic x-ray equipment becomes effective Aug. 1 of this year. This equipment standard primarily applies to manufacturers and assemblers but users are also affected.

Under the standard, x-ray manufacturers are resonsible for producing equipment and components that perform according to requirements of the standard. Assembler's primary responsibility is to install the system according to the manufacturer's specifications and to use the type of components called for by the standard. He must certify that these two conditions have been met by filing specified forms with the Food and Drug Administration's Bureau of Radiological Health, the State Radiation Control Agency, and the purchaser.

One of the principal protection provisions of the standard requires machines to be capable of restricting the x-ray beam to the size of the film or fluoroscopic image receptor. The standard also contains provisions intended to make it possible for operators to reproduce more consistently a given image quality for given voltage, current, and time settings. This capability, in combination with good x-ray examination techniques, will tend to minimize film retakes and unnecessary exposure.

To familiarize persons who are affected by the new standard, especially commercial installers and users who may perform their own installations, with their responsibilities under the new regulations, workshops are being conducted by the Food and Drug Administration. These one-day sessions are being held in various parts of the U. S. Persons interested in attending are urged to contact the FDA Radiation Control Officer in their region for additional information. Workshops will also include discussions of proposed federal requirements involving resale of used x-ray equipment.

For workshops scheduled in this area contact: Thomas R. Johnson, Jr., Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee), 880 West Peachtree St., N.W., Atlanta, Ga. 30309, Telephone: 404-526-3576, or Paul A. Dickson, Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, Texas), Room 470B, 500 South Ervay St., Dallas, Tex. 75201, Telephone: 214-749-2225.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 22-26, 1974, Chicago. Clinical Convention, Dec. 1-4, 1974, Portland, Ore. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 68th Annual Scientific Meeting, Nov. 18-21, 1974, Atlanta. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

Tennessee Valley Medical Assembly, Annual Meeting, Sept. 30-Oct. 1, 1974, Chattanooga. Mrs. F. M. Richardson, Executive Secretary, 960 E. Third St., Chattanooga, Tenn. 37403.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 11-13, 1974, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 106th Annual Session, May 6-9, 1974, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, The Field Clinic, Centreville 39631, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, B6 Medical Arts Building, 1151 N. State St., Jackson 39201, Secretary.

Claiborne County Medical Society, First Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, P.O. Box 147, Port Gibson 39150, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April, and First Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, P.O. Box 128, Summer 38957, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, and November. J. H. Gaddy, 4502 15th St., Gulfport 39501, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando 38632, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian 39301, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez 39120, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. Robert B. Townes, 1196 Mound St., Grenada 38901, Secretary.

Northeast Mississippi Medical Society, First Thursday, March, June, September, and December. Jack A. Stokes, 207 Holmes Rd., Pontotoc 38863, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford 38655, Secretary.

Pearl River County Medical Society, Second Monday. March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune 39466, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. W. C. Welch, P.O. Box 5448, Mississippi State 39762, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Jeff Hodges, 1365 Market St., Pascagoula 39567, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb 39648, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie St., Hattiesburg 39401, Secretary.

West Mississippi Medical Society, Third Monday, January, March, May, September, October and November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, The Street Clinic, Vicksburg 39180, Secretary.

Unnecessary Medication Halt Urged

A call for a vast program to educate the public that they do not need a shot or a pill every time they see a doctor is voiced in the Mar. 4 issue of the *Journal of the American Medical Association.*

"The simple truth is this—many patients seen in the office of the general practitioner or internist need little, sometimes no, medication," says *JAMA* Editor Dr. Robert H. Moser.

Over-medication occurs in the hospitals as well as in doctors offices, and authors Henry L. Simmons, M.D., and Paul D. Stolley, M.D., call for more stringent review and control programs in hospitals to make certain that penicillin and other antibiotics are used properly.

Most people who go to the doctor expect some medication, Dr. Moser says. They do not feel the doctor has completed his treatment until he gives them a shot or hands them a prescription to be filled at the drug store. The doctor is busy, other patients are waiting, and the quickest way for him to terminate the visit is to write a prescription and hand it to the patient.

This combination of circumstances has resulted in the overuse of medications, especially penicillin and other antibiotics, *JAMA* declares.

Seeking answers to the antibiotic questions, the AMA recently convened a panel of expert scientists. The *JAMA* articles are the result of the deliberations of this committee, plus additional comment.

"Hundreds of thousands of patients may be unnecessarily exposed to the hazards of antibiotics because of their inappropriate use," says Drs. Simmons and Stolley. They are from the Social and Rehabilitation Service of the U. S. Department of Health, Education and Welfare, Washington, D. C.

Simmons and Stolley declare that more than half of all prescriptions written by physicians in their offices for the common cold are antibiotics or penicillin. The cold is caused by viruses, which are not affected by antibiotics. They also point out that one quarter to one third of all patients in general medical and surgical wards in hospitals are given an antibiotic drug during their hospital stay, even though in many cases there is no evidence of infection that would require such treatment. Outside the hospital, almost 200 million prescriptions a year for antibiotics are being filled in community pharmacies.

It isn't all bad, they point out. Decline in mortality from once fatal diseases such as pneumonia, meningitis, rheumatic fever and syphilis represents one of the great triumphs of modern medicine.

Recommendations for antibiotic controls in hospitals are fourfold: (1) Each hospital should form a committee to monitor antibiotic usage. (2) The committee should develop individualized guidelines for appropriate antibiotic usage both for treatment and prophylaxis (prevention of infection). These guidelines should be approved by the executive committee of the medical staff. (3) The report of the antibiotic committee would be distributed internally to the medical staff and the executive committee. (4) There would be an annual review of antibiotic usage by an outside consultant who would submit written recommendations to the executive committee.

An ever present danger in use of antibiotics in treating disease is that germs develop resistance to the medication. Antibiotics are primarily effective against bacteria known as Gram-positive organisms. With widespread use of antibiotics, there has been an ecological shift of the harmful bacteria to another type, known as Gram-negative. These do not respond to most antibiotics. Emergence of drug-resistant strains of gonorrhea has been known for years.

Other problems are a severe allergic reaction to penicillin on the part of some patients, and aplastic anemia which sometimes follows administration of chloramphenicol.

The *JAMA* articles do not suggest that antibiotics not be used in treatment. They are much too useful in curing many diseases. They suggest only that more care be used in prescribing.

John C. Ballin, Ph.D., director, and the staff of senior scientists of the AMA Department on Drugs, point to some of the sound reasons behind the wide use of penicillin and other antibiotics.

A larger percentage of the population is getting better medical treatment than ever before, Dr. Ballin and colleagues point out. Laboratory and clinical techniques for diagnosing and treating infectious diseases have been greatly improved in recent years. Millions of doses of antibiotics are now given to patients with acne, and, the number of useful antibiotics is increasing.

Considering the prevalence and wide variety of diseases for which antibiotics are indicated, it is probable that this class of drugs *should* be the most widely used, they declare.

Dr. Longmire Speaks at UMC Surgery Meet



Dr. William Longmire, professor and chairman of the surgery department at the University of California School of Medicine, was one of nine nationally-known surgeons brought together at a University Medical Center surgery conference in Jackson Mar. 14-16. Over 150 surgeons from 25 states came to Jackson for the three-day event. The conference, sponsored by the UMC Department of Surgery and the Continuing Education Committee, brought together surgeons to discuss the latest knowledge and techniques in surgical emergencies of the abdomen.

Thrombosis, Hemostasis Conference Set

A National Conference on Thrombosis and Hemostasis will be held in Dallas, Nov. 20-22, 1974, sponsored by the Council on Thrombosis of the American Heart Association.

The meeting will provide a national interdisciplinary forum for the discussion of new scientific and medical advances relating to the problems of thrombosis and hemostasis.

Symposia are planned on the Relationship Between Thrombosis and Atherosclerosis; Initiation Mechanisms of Coagulation; Thrombosis Regulating Mechanisms; Prosthetic Devices, Surfaces and Thrombogenesis; and Thrombotic Disease: Diagnosis and Therapy.

Workshops involving specific problems in blood platelets, coagulation, and immunology are included in the program. Abstracts will be solicited for free communications. All interested are invited to attend. No registration fee is required for members of the Council on Thrombosis or for those registered for the Scientific Sessions of the American Heart Association. All others will pay a registration fee of $50.

For further information and for abstract forms write to Section on Scientific Programs, American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.

Leukemia Grant Applications Are Available

Investigators whose interests are centered on the problems of leukemia may apply now to the Leukemia Society of America, Inc. for financial grants to support their individual projects.

Deadline for submitting completed applications is Oct. 1, 1974, according to Dr. Joseph H. Burchenal, the society's vice president for Medical and Scientific Affairs. Proposals will be reviewed next January by the committee he heads, with approved funding to become effective in July 1975.

In line with its established policies, the national voluntary health agency confines its grant support strictly to post-doctoral researchers whose work may be expected to lead to an understanding of the causes of and hopefully a cure for leukemia and related disorders of the blood-forming organs, Dr. Burchenal emphasizes. Candidates may be of any age, color, sex or creed, he points out, and they need not be American citizens. However, because of last year's unprecedented number of applications and an anticipated increase again this year, only one application in each grant category from an individual sponsor at a sponsoring institution will be considered.

Three types of funding are available from the society. They are:

Scholarships: Five year grants for a total of $100,000 for those who have demonstrated distinct ability in the investigation of leukemia.

Special Fellowships: Two year grants for a total of $31,000 for those who have demonstrated ability in post-doctoral research whose qualifications place them between Scholar and Fellow status.

Fellowships: Two year grants for a total of $19,000 for promising younger investigators to encourage their work in leukemia research.

In exceptional circumstances, emergency small grants up to $3,000 may be awarded for one year to initiate or implement a research program.

Application forms may be obtained by writing to the Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 East 43rd Street, New York, N. Y. 10017.

College of Sports Medicine Meets

The 21st Annual Meeting of the American College of Sports Medicine will be held May 9-11, 1974, at the Regency Hyatt Hotel in Knoxville, Tenn.

The final program includes 94 scientific papers to be presented during free communications sessions and six formal symposia. Symposia titles include: nutrition and performance; respiration during exercise; sideline decisions—a practical approach to clinical recognition and immediate management of injuries in athletes; neuromuscular and biomechanical aspects of power events in track and field; coronary heart disease rehabilitation; and hormonal response in exercise.

Special sessions include: mini-symposium on computers in sports medicine; physiological aspects of cycling; guidelines for graded exercise testing and exercise prescription progress report; innovations in teaching exercise physiology; and psychological effects of physical activity.

Dr. Ulf Svante von Euler, Nobel laureate from Stockholm, Sweden, will address meeting attendees at the Third Annual Joseph B. Wolffe Memorial Lecture. Dr. von Euler's lecture is entitled "Sympathetic Nerve Activity in Physical Exercise."

Social functions planned for the meeting include an early bird reception with the Board of Trustees on Wednesday evening and a reception and awards banquet on Friday evening.

The program has been approved for 15 prescribed credit hours by the American Academy of Family Physicians.

For further information contact: J. Grove Wolf, Acting Executive Secretary, American College of Sports Medicine, 1440 Monroe St., Madison, Wisc. 53706.

Dialysis Used in Reye's Syndrome

A new use for a familiar technique, peritoneal dialysis, is saving the lives of an unprecedented number of Reye's syndrome patients, according to an article in the March issue of *Pediatrics*, the official publication of the American Academy of Pediatrics.

Dr. Frederick J. Samaha, primary author, reported that in 24 cases of Reye's syndrome seen between 1968 and 1972, 82 per cent of those treated with peritoneal dialysis in addition to standard therapy lived; only 15 per cent of those treated with standard therapy alone survived.

Reye's syndrome is a relatively rare disease that was discovered only 10 years ago. In the past year, the U. S. Center for Disease Control has reported 90 cases from Colorado to New England. The syndrome affects children up to 17 years of age and has a mortality rate of 50-100 per cent. It commonly follows a mild viral infection like the flu. First sign of the syndrome is persistent vomiting, followed by serious liver involvement, delirium or seizures. Frequently the patient slips into a hepatic coma from which he never recovers.

Peritoneal dialysis reverses the coma in many cases by cleaning the blood of certain impurities such as ammonia, normally removed by the healthy liver. The procedure consists of injecting fluid into the abdominal cavity where, through osmosis, the fluid cleans the blood and is drained out after 15-20 minutes. Then the whole process is repeated. When performed by experienced personnel, it is safe, effective, and can be carried out in most hospitals.

In the opinion of Dr. Samaha, "Peritoneal dialysis is a therapy which may offer hope in reversing the high mortality of Reye's syndrome when used before there is evidence of irreversible brain stem damage."

The 24 patients seen ranged in age from two months to 13 years. Twenty-three were admitted to Children's Hospital of Pittsburgh, and one to Babies Hospital in New York City. All children had a mild infection, seemingly viral, which occurred about one week before admission. Every patient but one had repetitive vomiting, delirium, disorientation or seizures before coma ensued.

Dialysis was performed for 24 to 72 hours until patients were awake, alert and oriented. The two patients who died in spite of dialysis were already in deep coma and had suffered brain stem damage before dialysis was started.

Additional authors of the article are Drs. Edward Blau and John Berardinelli, from the departments of pediatrics and neurology, University of Pittsburgh School of Medicine and Children's Hospital of Pittsburgh, Pittsburgh, Pa.

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IN CONCLUSION

The Mississippi Alcohol Safety Education Program is sponsoring an exhibit at the 106th Annual Session of the association and will demonstrate the Intoximeter used by the Highway Patrol. As a public education feature, the exhibit will be open evenings so interested parties can be tested after attending cocktail parties, etc. The MASEP was originally funded by State Board of Health, but is now under Miss. State University and Governor's Highway Safety Program.

America is making progress in the battle against heart disease, reports the March 4 JAMA. Although overall deaths from heart disease have increased, the death rate in the productive years of 35 to 64 has dropped. The increase has come among Americans of advanced years. Report runs counter to reports that we are having an epidemic increase in death rate from heart disease partly because doctors looked only at the crude death rate rather than the age-adjusted death rate.

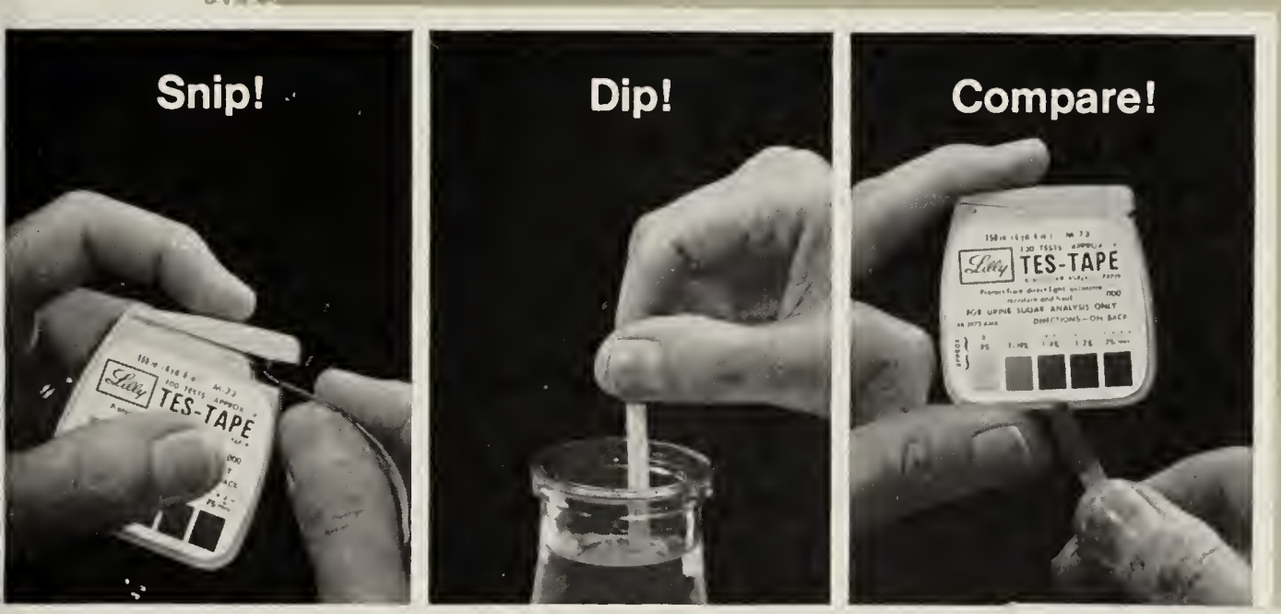
Episodes of gastroenteritis involving at least 387 persons in the U.S. were traced to ingestion of imported French cheeses. Enteropathogenic Escherichia coli was identified in both cheese and stool specimens. Cheeses associated with all reported episodes were identical except for shape and labels and were classified as Brie, Camembert or Coulonniers. This is the first adequately documented occurrence of enteropathogenic E. Coli foodborne disease in the U.S.

When reports of children's ingestion of toxic substances seemed to cluster consistently around four to six p.m., the staff of the Poison Control Center, Nassau Co. Medical Center, N.Y., did an informal study and checked with parents of poisoned children to see what activities had preceded ingestion. Parents indicated that a majority of the children had eaten light or no lunches. Staff concluded that hungry children foraging for food are in danger of being poisoned.

The American Academy of Pediatrics' Joint Committee on Physical Fitness, Recreation, and Sports Medicine has urged parents to "hold firm in their refusal to allow their children the inescapable risk-taking involved in owning and/or operating a minibike." Minibikes are particularly dangerous because of poor handling due to short wheelbase and small tires; insufficient acceleration; inadequate brakes; small size, which decreases visibility; and inadequate protection of drivers.

JOURNAL OF THE Mississippi STATE MEDICAL ASSOCIATION

JUNE 1974



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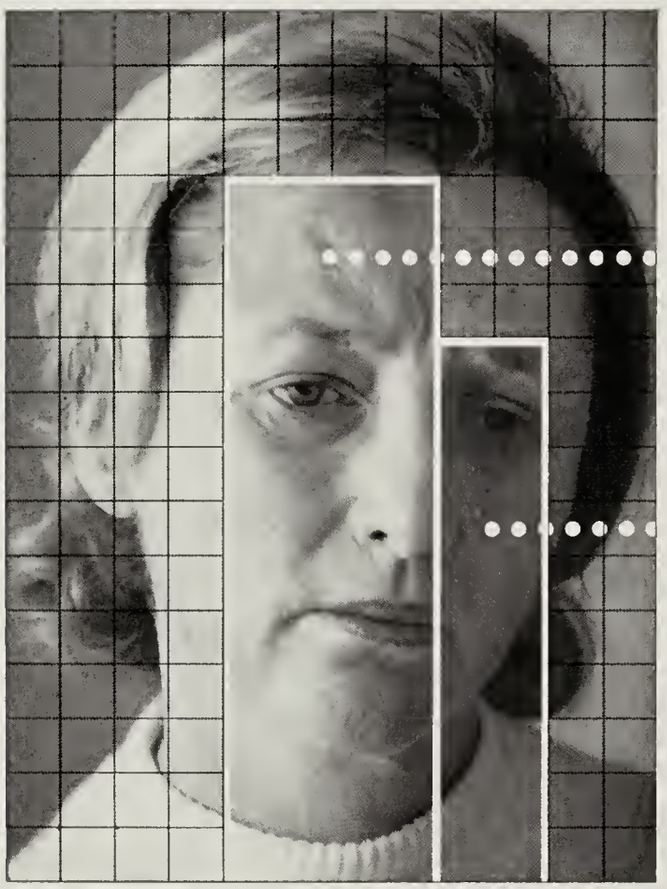
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Volume XV
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June 1974



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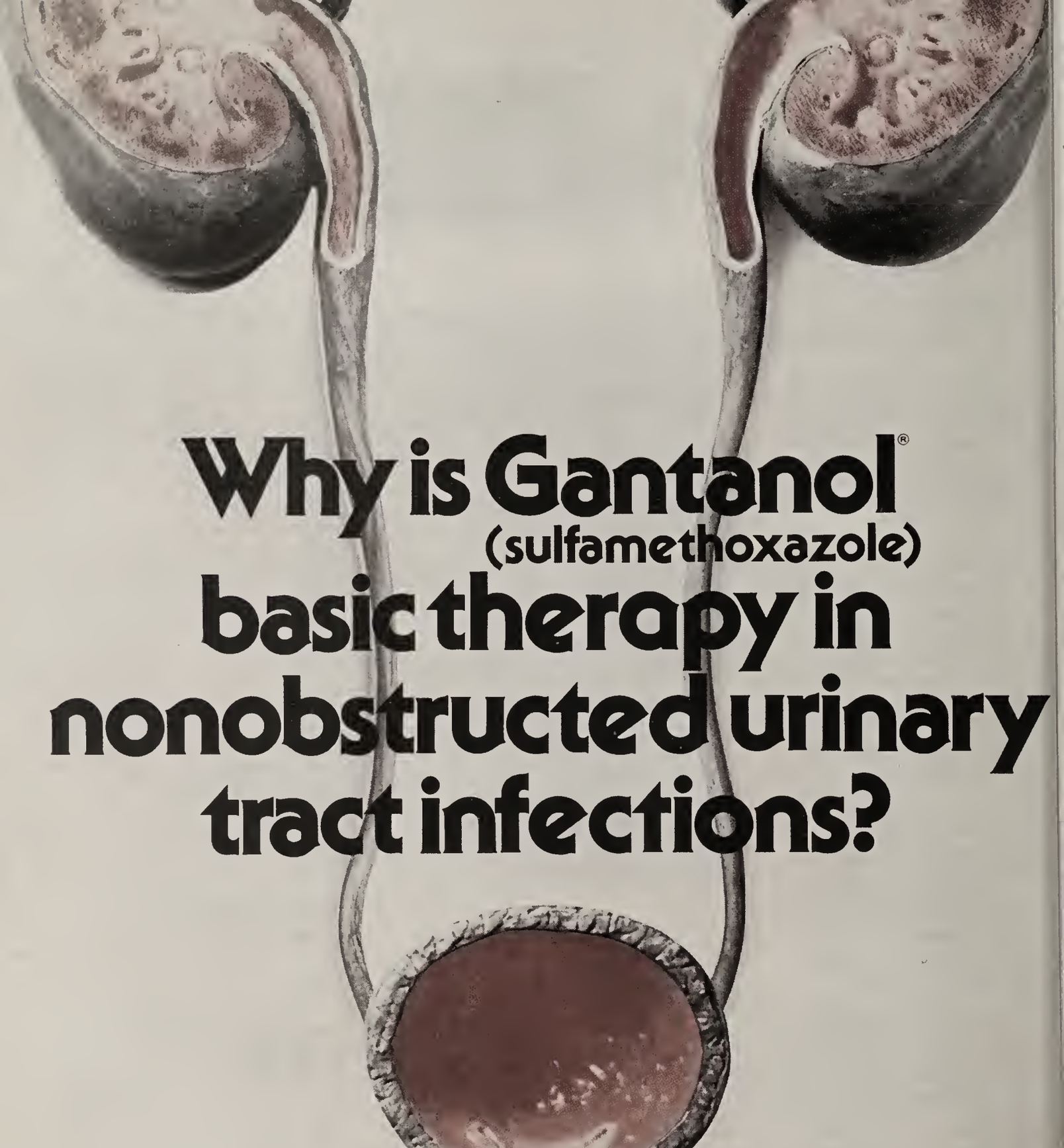
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NEWSLETTER

June 1974

Dear Doctor:

There were 9,845 more physicians in the United States at the end of 1973 than in the previous year, according to the AMA's Center for Health Services Research and Development. The final figure in the AMA master file of physicians at the end of the year was 366,379, compared with 356,534 at the end of 1972. The number of physicians providing patient care rose from 292,210 in 1972 to 295,257 last year. The number in medical teaching rose from 5,636 to 6,183.

The number of family physicians decreased from 55,348 in 1972 to 53,946 last year. Physicians in medical specialties rose to 86,924 last year from 84,153 a year earlier; those in surgical specialties rose to 91,549 from 91,058 in 1972. The number of M. D.'s in research dropped from 9,290 to 8,332.

Eleven cases of Hepatitis-A have occurred in Madison County since early March. All cases have been epidemiologically related to a single day care center in Canton, according to the State Board of Health. Children attending the center, employees and household contracts of known cases have all received immune serum globulin prophylaxis.

The 26th edition of AMA's "American Medical Directory" will be ready in July. The 1974 edition contains 371,000 biographical entries, 27,000 more than the last edition in 1969. Prepublication cost for the four-volume hard cover directory is $110. After June 30 the cost will go up $15. Directory may be obtained from the Order Department, AMA.

The 106th Annual Session on MSMA was recently conducted at Biloxi. (See convention coverage in this issue.) The Council on Scientific Assembly will soon begin working on next year's meeting. Council chairman Dr. James P. Spell of Jackson requests that any member with a suggestion or complaint write the council at MSMA headquarters in Jackson.

The National Endowment for the Humanities is instituting a series of humanities seminars for physicians and other health professionals. The seminars will focus on the ethical, philosophical and/or historical aspects of health care. For information write Prof. H. T. Engelhardt, University of Texas Medical Branch, Galveston, Texas 77550.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

"Socially Obstreperous" Are High Risk Drivers

Young or old, drinking or nondrinking, the "socially obstreperous" driver is more likely to die in an auto accident than is the more balanced man, says a report in the April issue of *Archives of General Psychiatry*, a publication of the American Medical Association.

A research team in Maryland studied the records of 50 men who died in traffic accidents in a four-year period in the Baltimore area. The researchers also interviewed family and friends to determine the social characteristics of those who died. They were cataloged on a scale measuring their degree of social adjustment as reflected by their behavior.

Those drivers who were belligerent, negative, inclined to talk to excess, hyperactive, and beset with emotional problems were much more likely to become fatalities in traffic accidents. These individuals also had a high record of traffic violations, and were more likely to have been drinking at the time of their fatal accident.

It may be that alcohol abuse is associated with social aggressiveness, the report says.

Mean age of drivers in the study was 34 years. Half had one or more prior speeding convictions; 22 per cent had prior convictions for reckless or drunken driving. Twenty-eight per cent had had their licenses suspended or revoked. Some 76 per cent died in single car accidents. Three-fourths had some alcohol in their system, and more than half had enough alcohol to impair driving ability.

Principal investigator in the study was John W. Shaffer, Ph.D., of the Johns Hopkins University School of Medicine, Baltimore. Others were Wayne Towns; Chester W. Schmidt, Jr., M.D.; Russel S. Fisher, M.D., and Howard I. Zlotowitz, all of Baltimore. Dr. Fisher is chief medical examiner for the State of Maryland.

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DATELINE

Dr. Welby Will Teach Next Fall

Kansas City, Mo. - "Marcus Welby, M. D.," television's family doctor, will combine teaching with healing in his video pursuit of the art of medicine Tuesday nights on ABC next fall, according to the American Academy of Family Physicians. The series will recast Welby in the role of "director of the family practice training center at Lang Memorial Hospital" as well as continuing to carry on his family practice in Santa Monica.

AMA Placement Service Works

Chicago, Ill. - About 200 physicians were placed last year through the AMA's Physicians' Placement Service. The PPS will have an exhibit at the AMA's annual convention in Chicago in June, where more than 2,000 physician resumes will be available to those seeking partners or associates. The placement service is free and those interested in having their resumes circulated are urged to write AMA early for registration forms.

Society Publishes Roster of Members

Chicago, Ill. - The 1974 Roster of the Society of Professional Business Consultants has been completed and is available to physicians interested in locating a business advisor. The society is a national organization of business advisors to physicians and dentists. To obtain a free copy of the roster, write on your letterhead to the Society of Professional Business Consultants, 221 North LaSalle Street, Chicago, Illinois 60601.

Some Children Need to Restrict Milk

Evanston, Ill. - Milk drinking should be restricted in children with three types of health problems, but for most children "drinking moderate amounts of milk has no apparent adverse effects and is nutritionally beneficial," the American Academy of Pediatrics Committee on Nutrition has said. Milk intake should be restricted in: (1) the child with nutritional iron deficiency; (2) the child with anorexia; and (3) the child who tends to be constipated.

AMA is Against Forced Retirement

Chicago, Ill. - The AMA will join in a suit to declare unconstitutional a federal law requiring mandatory retirement of U. S. Civil Service employees at a particular age. The AMA expressed its firm opinion that "workers who are capable and who personally desire to postpone retirement should be encouraged to do so by adoption of flexible retirement policies by both industry and government. Biological age, not chronological age, should be used in deciding when a man should retire."

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Chest Diseases To Be Studied in London

The interface between heart and lung disease will be the theme of the XII International Congress on Diseases of the Chest, July 7-12, 1974, in London, England. A select number of manuscripts, heretofore unpublished and original, will be presented.

The congress, to be held at Royal Festival Hall, is sponsored by the International Academy of Chest Physicians and Surgeons, affiliated with the American College of Chest Physicians.

Two thousand physicians from 56 countries are expected to attend the congress, which will feature medical symposia on: Airway Obstruction, Lung Defense and Lung Clearance, Coronary Heart Disease—Medical vs. Surgical Treatment, Lung Cancer, Congenital Heart Disease—at All Ages, Current Problems of Rheumatic Mitral Valve Disease and The Reaction of the Respiratory Tract to Irritants.

Plans for opening day of the congress include a nurses symposium and a series of 15 clinic visits to hospitals and teaching centers in London. In addition to the symposia there will be tutorial sessions, luncheon panels, scientific seminars and medical motion pictures.

The objectives of the XII International Congress on Diseases of the Chest, as outlined by the college, are to:

—Solicit heretofore unpublished and original information from physicians and surgeons for presentation to an international audience of chest specialists;

—Present subjects and themes of foremost scientific interest in the areas of respiration, circulation, and related systems;

—Establish fruitful dialogue between physicians and surgeons from all countries, and between teachers and their audience;

—Initiate debates and encourage the development of new thoughts;

—Build, establish, affirm and stimulate international good will and professional solidarity."

After April 1, 1974, registration fee for the congress is $65 for ACCP members and $95 for nonmembers. Further registration and fee information is available from: XII International Congress of Diseases of the Chest, c/o American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
June 1974, Vol. XV, No. 6

ORIGINAL PAPERS

Seminar in Neuropathology: Part I

J. BEBIN, M.D., Ph.D.
Jackson, Mississippi

Introduction. The purpose of this seminar is to present and discuss certain of the most interesting diagnostic problems in brain tumors encountered in daily practice. The selection of cases for a seminar of this type has multiple objectives: The material should be of interest to the participants and it may assist them in their diagnostic work. The selected cases should serve as a point of departure for discussion of groups of related entities and should be useful in subsequent instruction of residents and postgraduates.

It is possible that one could devote an entire session in neoplasms of the central nervous system to the astrocytoma group or to the sarcoma group, but it was thought that a brief consideration of a wider range of neoplasms of the central nervous system rather than a more specific discussion of a small number of closely related entities would be more useful. This is reflected in the selection of the cases for discussion which represent a broad spectrum of tumors of the central nervous system.

CARCINOMATOUS MENINGITIS

Case No. 1: A 58-year-old white man was admitted to the hospital on Sept. 21, 1973, with pain in the right shoulder, cervical, left intrascapular areas, and left upper arm, of one month's duration. There was tenderness and pain on palpation over the left brachial plexus. He had no muscle weakness but C_6 hypalgesia on the left. Reflexes were normal except for a markedly decreased right biceps reflex. A week later he was thought to have developed some right sided weakness. There was a history of depression and he was being treated for this by the psychiatry service. Brain scan was normal but the EEG was markedly abnormal: generalized slowing to 6 per second, and bifrontal delta waves. CSF examination results were: OP was 330, glucose 25 mg per cent, protein 426 mg per cent; 34 cells (93 per cent lymphs).

Skull films were normal; cervical spine films showed moderate degenerative changes. Gallbladder and upper GI series done in May 1972 showed a diverticulum of proximal portion of the duodenum and probable cholelithiasis. Left internal carotid arteriogram results were: questionable elevation of first portion of left anterior cerebral artery.

Patient was placed on antifungal, antituberculosis drugs and other antibiotics. A second lumbar puncture showed atypical cells in the CSF, suggestive of neoplasm.

He became markedly confused and febrile; had a progressively downhill course and expired on Oct. 16. An autopsy was performed.

The diagnosis in this case is Carcinomatous Meningitis, the primary site being pancreatic adenocarcinoma.

The autopsy disclosed a greatly enlarged pancreas with hard lobular masses in the body of the organ which on microscopic examination consisted of an adenocarcinoma. This neoplasm infiltrated the peripancreatic tissues and invaded the left adrenal gland. It also had metastasized to periaortic lymph nodes and the central nervous system.

The brain was edematous with increased weight (1490 grams), cloudy leptomeninges over the convexity and a whitish "exudate" on its basal aspect. This appearance was striking on the orbital surface of the frontal lobes, chiasmatic region, interpeduncular space and ventral surface of the cerebellar hemispheres. Similar opaque, whitish "exudate" was apparent in the meninges of the spinal cord around the roots of the cauda equina. Thin serial sections

---

Presented at the Tri-State (Ala.-La.-Miss.) Pathology Meeting, Jan. 29, 1974, Biloxi, Miss.
From the Department of Pathology, University of Mississippi School of Medicine, Jackson, Miss.

of the brain and spinal cord revealed no gross metastatic lesions. The ventricular system was symmetrically dilated.

Microscopic examination of multiple selective blocks of cerebrum, brain stem, cerebellum and spinal cord was performed. No intraparenchymatous lesions were found. In the leptomeninges there was a diffuse infiltrate of neoplastic cells, occasionally exhibiting an adenomatous arrangement, but more often several cells thick and without any particular pattern. The tumor cells ensheathed the meningeal blood vessels within the subarachnoid space and, in a few instances, especially in the cerebellum, continued for a short distance as cellular cuffs along the perivascular spaces (see Figures 1 and 2). The most significant and informative sections were those taken from the cerebellum, interpeduncular region, brain stem, spinal cord and cauda equina roots. The tumor infiltration of the leptomeninges was particularly dense on the ventral aspect of the cerebellum and dorsal aspect of the spinal cord. The spinal root and and the dorsal root ganglia also showed varied degrees of tumor infiltration.

This case illustrates very well the difficulties in the diagnosis of pancreatic tumors, especially when they are not accompanied by jaundice as one of the clinical manifestations. The silent nature of these tumors and the frequency of symptoms referable to metastasis have been emphasized by Duff. Ductal carcinomas of the pancreas are the most common malignant neoplasms of this organ, constituting 81 per cent of all primary carcinomas of the pancreas (Miller & Baggentos, Cancer 4:233, 1951). They frequently arise in the head of the pancreas (71 per cent). Jaundice occurred in 128 of 144 cases (89 per cent). Invasion of the perineural lymph spaces occurs in about 70 per cent of all cases.

The neurologic manifestations encountered in carcinoma of the pancreas, as well as in other visceral carcinoma, are due to invasion of the CNS and its meninges. In recent years the association of neurologic symptomatology with carcinomas in the absence of direct involvement or metastasis in the CNS has been emphasized. Several clinico-pathologic syndromes have been described. Of these, three apparently occur more frequently than others: (1) subacute degeneration of the cerebellum (Greenfield 1934); (2) peripheral neuropathy and myelopathy, occurring principally as sensory neuropathy (Denny-Brown 1948); and (3) myasthenoid syndromes.

This case has the features of direct invasion of the leptomeninges and spinal nerves, dorsal roots and ganglia by a carcinoma of the pancreas.

Diffuse invasion of the leptomeninges by systemic cancer (meningeal carcinomatosis) was first reported by Eberth in 1870 who studied in a case the association of a pulmonary epithelioma and an endothelioma of the leptomeninges. Since then more than 250 cases, singly or in series, have been described in the literature, Fisher-Williams and associates (1955); Grain and Karr (1955); Olson et al (1974) and Little et al (1974) have provided excellent reviews of this subject.

Any malignant tumor, primary or secondary, in the CNS, if it encroaches on the ventricular or pial surfaces, may release tumor cells into the CSF and produce implant metastases in the ventricles or leptomeninges. Excluding malignant lymphomas and the leukemias, in which leptomeningeal invasion is not rare, the most frequent source of meningeal metastasis, according to Olson et al, in a study of

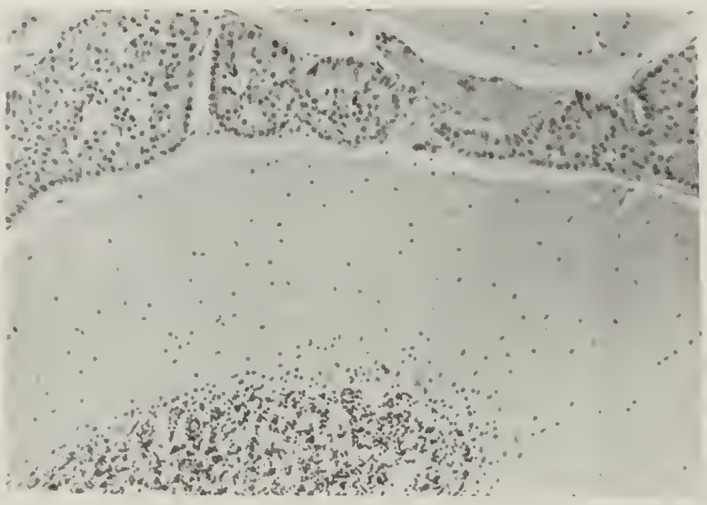


Figure 1. Case No. 1: Cerebellum showing a diffuse infiltration of leptomeninges by adenocarcinoma. H & E × 200.

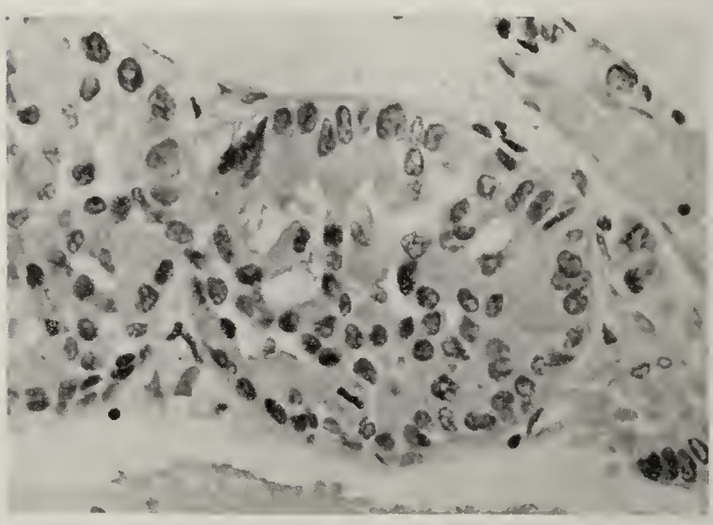


Figure 2. Case No. 1: Higher magnification of an adenocarcinoma in the cerebellar leptomeninges. H & E × 400.

50 patients are: breast (36 per cent); lung (16 per cent); malignant melanoma (10 per cent), adenocarcinoma of the pancreas (4 per cent); anaplastic renal carcinoma and embryonal sarcoma, each one case. In early European reports a number of instances were reported in which gastric carcinoma metastasized to the leptomeninges. The decreasing incidence of this type of cancer in this country undoubtedly accounts for this discrepancy. Aronson et al (Cancer 17:558, 1964) in an autopsy study of 9,114 cases, encountered 2,046 cases of cancer. Of these, 397 (16.5 per cent) metastasized to the CNS. The primary source was: lung (46 per cent), breast (13 per cent), GI tract (13 per cent), pancreas (2 per cent), urinary tract (3 per cent), melanoma (3 per cent), other and unknown (4 per cent).

The mechanisms involved in invasion of the leptomeninges is controversial. The absence of lymphatics in the CNS implies that such metastases are blood-borne. Cases in which there is no evidence of tumor in the dura, parenchyma or epidural segments of nerve roots, suggests that there is direct invasion of CSF through the choroid plexus or leptomeningeal vessels. Tumor metastasis in the parenchyma near the cortex or subependymal plate could be a source of tumor spread to the leptomeninges. Cases with tumor cells within the spinal roots or in the perineural spaces suggest a direct invasion of the CNS through this route. The present case shows invasion of the peripancreatic nerves and of the posterior roots and ganglia by neoplastic elements.

It is not clear how leptomeningeal invasion by carcinoma produces the neurological signs and symptoms. It appears that, in most patients, cerebral symptoms such as mental dullness, dementia and depression, may result from ventricular dilatation; the algias and peripheral symptoms from invasion of spinal roots and peripheral nerves by the neoplasm. The signs of meningeal irritation appear to be due to the involvement of the leptomeninges by the tumor, as well as the inflammatory response that may sometimes be elicited.

The differential diagnosis of meningeal carcinomatosis is often very difficult. The majority of cases reported were diagnosed only at autopsy. The most useful test is examination of the CSF. The following changes when present are very important in the diagnosis: (1) increased pressure and protein content; (2) pleocytosis with presence of "atypical" or tumor cells; and (3) hypoglycorrhachia (from 0 to 25 mg/100 ml). The nature of the latter is obscure. Olson et al consider that there is an active glycolysis in the CNS due to the increased metabolism in tumor cells enmeshed in the leptomeninges.

Histologically the most important differential lesion is a papilloma of the choroid plexus. The orderly arrangement of the choroidial epithelium with its cuboidal cells containing single nuclei contrasts with the luxuriant proliferation of atypical cells and abundant mitoses present in metastatic carcinomas. The distinction from a rare occurrence of carcinoma of the choroid plexus can be made only with certainty if no primary carcinoma is found at autopsy.

REFERENCES

1. Fisher-Williams, M., Bosanquet, F. D. and Daniel, P. M.: Carcinomatosis of the Meninges, a Report of Three Cases. Brain 78:42-58, 1955.
2. Grain, G. O. and Karr, J. P.: Diffuse Leptomeningeal Carcinomatosis. Clinical and Pathological Characteristics. Neurology 5:706-722, 1955.
3. Olson, M. E., Chernick, N. L. and Posner, J. B.: Infiltration of the Leptomeninges by Systemic Cancer. Arch. Neurology 30:122-137, 1974.
4. Little, J. R., Dale, A. J. and Okazaki, H.: Meningeal Carcinomatosis. Arch. Neurol. 30:138-143, 1974.
5. Aronson, S. M., Garcia, J. H. and Aronson, B. E.: Metastatic Neoplasms of the Brain: Their Frequency in Relation to Age. Cancer 17:558-563, 1964.

BRAIN TUMOR: RECURRENT OLIGODENDROGLIOMA OF RIGHT CEREBRAL HEMISPHERE

Case No. 2: A 53-year-old white male executive was in good health except for mild hypertension, until early 1969 when he experienced gradual behavioral changes. In May 1969 a grand mal seizure with some left lateralization occurred. Multiple hospital admissions and evaluations by neurologists and neurosurgeons resulted in a diagnosis of cerebral arterial insufficiency due to arteriosclerosis and hypertension. The behavioral changes progressed to total disability. In early 1971, he was admitted to the VA hospital. Evaluation there revealed signs and symptoms suggesting a right frontal lobe lesion which was confirmed by arteriograms. Craniotomy and subtotal removal of a "modest sized" tumor was performed. This was interpreted a Grade I to II astrocytoma. Postoperatively radiation of 5000 rads was given. He experienced some physical improvement but continued behavioral deterioration. A brain scan in August 1971 revealed evidence of "tumor recurrence" in the right temporo-frontal area. The course was progressively downhill with focal and generalized seizures, terminating in coma and death in April 1973. Autopsy revealed pulmonary aspiration with bronchopneumonia and massive right cerebral tumor. A section of the latter is included as Figure 3.

Autopsy here revealed an edematous and asym-

metric brain weighing 1725 grams with bilateral temporal and cerebellar pressure cones. The right cerebral hemisphere was enlarged because of diffuse infiltration by a glioma. The tumor involved the frontal, parietal and temporal lobes, the basal ganglia, thalamus and the island on the right. A cystic cavity was present in the frontal pole where surgery had been performed. The wall of the cavity was irregular and extended to the anterior portion of the frontal horn of the lateral ventricle. On cut sections the neoplasm appeared poorly delimited and contained gray-pink and grayish granular soft areas alternating with other pale, rubbery and necrotic areas. The ventricular system was dilated and compressed from right to left. The midbrain showed similar deformity and on sectioning there was tumor infiltration of the collicular and tegmental regions. The pons, medulla and cerebellum were edematous and congested.

Microscopic examination of multiple sections of frontal, parietal, occipital lobes, basal ganglia, thalamus, brain-stem and cerebellum was made. This showed a very cellular neoplasm made up of fairly uniform hyperchromatic elements (oligodendroglia cells) with round or oval nuclei, granular chromatin, and scanty unstained cytoplasm leaving a clear halo around the nuclei (see Figure 3). Mitoses were rarely observed but amitotic divisions were frequently seen. Foci of calcification were observed within the tumor and in the adjacent cerebral tissues. This neoplasm diffusely infiltrated both gray and white matter. In the latter the cellular elements were typical oligodrendrogliocytes. In the cortex, which was also infiltrated, many of the cells appeared as neuronal satellites. Certain fields showed an admixture of oligodrendrogliocytes and astrocytic cells, a feature commonly encountered in oligodendrogliomas. The blood vessels were numerous and thin walled. Only occasionally was there a certain degree of endothelial hyperplasia. Re-examination of the previous biopsy (S71-1103) revealed a similar neoplasm (oligodendroglioma) with no significant structural differences in cellular appearance, presence of calcification, etc.

Oligodendrogliomas constitute 4-7 per cent of all primary intracranial neoplasms in man. Kernohan, in examining 8,784 brain and spinal cord tumors, found 365 oligodendrogliomas (3.8 per cent), of which only 8 were intraspinal.

Oligodendrogliomas occur predominantly in the cerebral hemispheres and rarely elsewhere. Zulch in a series of 67 cases found: 27 frontal, 16 temporo-occipital, 8 parieto-occipital, 10 parasagittal, 5 in the brain stem and none in the cerebellum. They are

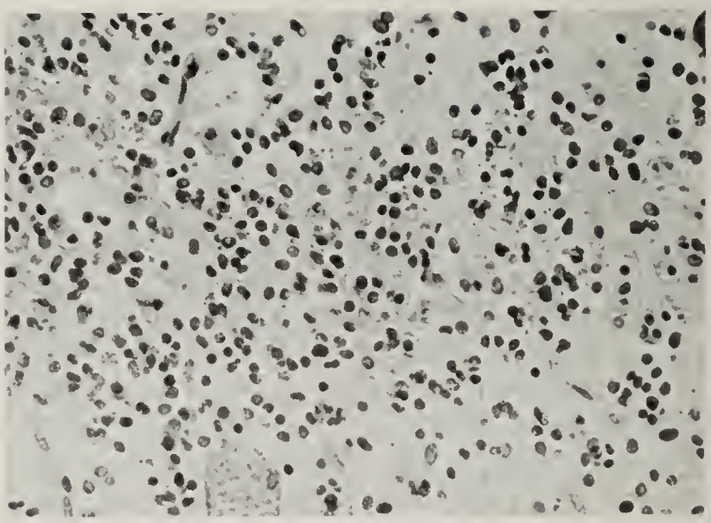


Figure 3. Case No. 2: Showing the general architecture and cytologic appearance of the tumor. H. & E × 200.

tumors of adults, the average age at occurrence between 38 to 42 years, and there is no sex predilection.

The gross appearance of oligodendrogliomas is not uniform; indeed, many are cystic (20 per cent). The microscopic picture, however, is more often uniform and diagnostic. Other types of glial cells, such as astrocytes, are frequently present and the vascular changes are mild. Calcification within the tumor or in the adjacent brain is common. It occurs radiologically in about 39 per cent of cases and microscopically can be seen in 70 per cent of oligodendrogliomas. Malignant changes may occur, reversing the earlier concept of a benign, slow growing neoplasm with a good prognosis into a neoplasm of "unpredictable" behavior. Elvidge et al found evidence that the speed of growth increases late in the evolution of the tumor, or that operation appeared to increase that rate. Kernohan initially separated them into two categories: Oligodendroglioma (benign) and oligodendroglioblastoma (malignant). Recently, however, he considers such a distinction to be unreliable, if not impossible. In his series the average postoperative survival time was 48 months. Metastatic dissemination in the neuroaxis through the CSF is well known to occur. The prognosis is uncertain and recurrences appear in 50 per cent of the cases (Roberts and German). ★★★

2500 N. State Street (39216)

REFERENCES

1. Earnest, F., Kernohan, J. and McKeraig, W.: Oligodendrogliomas. Arch. Neurol. and Psych. 63:964, 1950.
2. Weir, B. and Elvidge, A. R.: Oligodendrogliomas—An Analysis of 63 Cases. J. Neurosurg. 29:500, 1968.
3. Zulch, K. J.: Brain Tumors, Their Biology and Pathology. New York: Springer, 1957.
4. Kernohan, J.: Oligodendrogliomas. In Minkler's Pathology of the N. S., Vol. II. New York: McGraw-Hill Book Co., 1971, pages 1993-2007.

A Comparative Study of Benefits Under State Medical Assistance Programs

DEWEY D. GARNER, Ph.D.
University, Mississippi

This paper makes comparisons between the Mississippi Medicaid program and the programs of other states. A questionnaire was mailed to the director of the Medicaid program in every state to which 34 responded. Mississippi ranked high in percentage of eligibles utilizing program benefits and total claims submitted. Overall administrative costs compared favorably with the national average. Utilization of physician's services and the average number of physicians visits per recipient together with the utilization of prescription drugs were markedly higher than the national average. Expenditures for outpatient hospital and skilled nursing home services were below the national average. The most utilized drugs in the Mississippi Medicaid formulary differed in many respects to the composite drug list for all states.

ALMOST A DECADE has passed since the enactment of Title XIX of the Social Security Act, the federal Medicaid legislation. Most states have now participated in the program long enough to develop a somewhat stable pattern of activity. Mississippi began participation in Medicaid on Jan. 1, 1970. The objective of this paper is to make comparisons between the Mississippi Medicaid program and the programs of other states.

A questionnaire was mailed to the director of the Medicaid program in each of the states and Guam, Puerto Rico and the Virgin Islands. For comparative purposes, the questions conformed to the data format utilized in the Mississippi Medicaid Commission's annual report. Since there is no uniform format on a national basis for data compilation, some could not supply answers to all of the questions in the questionnaire. These are indicated by a dash in the appropriate column.

Thirty-four states responded to the questionnaire. Since it was obvious after perusing the data that extreme values were distorting certain comparisons, both the mean and median values were reported. For example, the total expended for claims in the last fiscal year for California and New York represented almost 50 per cent of the total dollars expended in the 34 state sample. The mean value was 179 million; the median value 76 million. The tabulated data represent the *latest* information available in each state. In most cases the time period overlapped the same period as Mississippi for fiscal year 1972.

Table 1 indicates the percentage of each state's population who were eligible for medical assistance together with the rate of change from the preceding year and the percentage of eligibles utilizing one or more of the program benefits. Mississippi ranked above the mean and median in percentage of eligibles as would be expected in a state with a low per capita income. However, Puerto Rico was a solid

From the Department of Health Care Administration, School of Pharmacy, The University of Mississippi, University, Miss.

leader with almost half of its population eligible for benefits. The number of eligibles increased dramatically, 28.1 per cent, in Mississippi during fiscal year 1972. This percentage increase was twice the rate of any other state, and it is largely attributable to two factors as indicated in the commission's report.

TABLE I

POPULATON ELIGIBILITY AND UTILIZATION RATES BY STATE

State	% of State's Population Eligible for Assistance	% Change From Preceding Year	% of Eligibles Utilizing One or More Program Benefits
Alabama	8.7	2.0	34.6
Alaska	5.0	—	—
California[1]	11.3	3.1	53.2
Colorado	6.7	7.1	25.7
Florida	8.0	0.2	54.8
Georgia	12.0	—	70.0
Guam	5.0	1.0	50.0
Hawaii	—	—	—
Illinois	8.8	5.1	90.5
Kentucky	9.8	1.3	43.1
Louisiana	11.0	0.5	58.0
Maryland	9.6	14.3	93.0
Michigan	9.2	9.0	61.7
Minnesota	7.6	0.7	85.0
MISSISSIPPI	12.6	28.1	68.1
Montana	4.7	4.7	51.2
Nebraska	5.3	2.1	86.1
Nevada	4.0	0.0	91.0
New Hampshire	4.6	10.5	78.0
New Jersey	9.8	6.7	38.0
New Mexico	9.8	-1.6	69.0
New York	13.2	1.5	—
North Dakota	4.0	0.0	66.8
Ohio	6.0	10.0	72.5
Oklahoma	10.4	6.6	90.0
Oregon	5.1	5.6	37.1
Puerto Rico	44.4	0.8	95.9
South Carolina	6.1	12.5	58.7
South Dakota	4.4	—	56.5
Texas	7.5	10.4	73.4
Utah	9.5	4.8	48.0
Virginia	6.0	5.0	70.1
Washington	6.8	3.4	51.7
Wisconsin	8.5	9.1	72.0
Mean	9.0	5.5	64.3
Median	8.0	4.75	64.3

[1] In this and succeeding tables the Secretary of the Health and Welfare Agency in California has asked that caution be utilized in making comparisons with their data since significant program changes made for a unique year.

TABLE II

NUMBER OF CLAIMS RECEIVED AND FUNDS EXPENDED BY STATE

State	Number of Claims Received	% Change From Preceding Year	Total Expenditures for Medical Services	Average Expended per Recipient
Alabama	4,132,299	—	77,390,304	1003
Alaska	18,040	—	3,543,759	231
California[1]	34,670,190	7.6	1,138,696,548	40
Colorado	7,327,637	9.8	74,305,266	293
Florida	—	—	83,408,527	280
Georgia	5,345,119	—	134,273,179	338
Guam	2,500	25.0	917,000	183
Hawaii	724,350	23.0	27,538,927	384
Illinois	13,873,829	18.6	505,909,616	43
Kentucky	6,073,157	-0.2	67,407,235	41
Louisiana	2,320,692	1.4	85,463,919	209
Maryland	4,717,959	24.0	117,810,000	328
Michigan	17,922,000	17.0	421,000,000	701
Minnesota	—	—	121,106,134	482
MISSISSIPPI	3,883,305	26.8	51,824,559	235
Montana	310,845	18.9	287,271	8
Nebraska	1,625,212	-0.2	54,942,684	175
Nevada	381,600	21.8	11,668,241	544
New Hampshire[2]	176,063	17.3	8,700,294	245
New Jersey	—	—	249,231,000	1170
New Mexico	897,475	—	18,224,445	183
New York	—	—	1,674,000,000	1671
North Dakota	195,743	—	15,737,140	604
Ohio	9,400,000	12.0	201,000,000	364
Oklahoma	1,112,035	-4.4	110,470,817	413
Oregon	949,192	13.0	38,311,730	210
Puerto Rico	4,761,469	9.2	67,704,989	59
South Carolina	—	—	31,625,682	290
South Dakota	83,110	5.2	11,744,679	502
Texas	11,492,397	88.6	322,724,296	504
Utah	259,000	17.0	1,677,576	124
Virginia	5,080,532	73.5	111,710,015	403
Washington	24,500,000	25.0	97,142,963	402
Wisconsin	1,458,743	13.1	169,337,283	132
Mean	5,644,637	19.3	179,616,087	376
Median	2,320,692	17.0	75,847,785	291.50

[1] Represents claims for 89% of the persons certified for Medi-Cal. Excludes Buy in Part B Medicare.

[2] Claims figures are for hospitals, physicians and all other vendors except druggists, dentists and extended care facilities.

1. Eligibility rolls expanded as delays in the determination and transfer of eligibility to a computerized file were solved.

2. A federal court order required the program to provide medical assistance to the caretaker relatives. Approximately 29,000 adults were added under the mandate.

Only the state of New Mexico had a decrease in the number of eligibles for medical assistance.

The percentage of Mississippi eligibles utilizing one or more of the program benefits was slightly above both the mean and median values.

Table II presents the total number of claims received together with the rate of change from the preceding year, the total cost of the medical services provided, and the average expended per recipient. While the number of claims in Mississippi is below the national average, it is above the median value. Mississippi's per cent increase in claims is reflective of the large increase in eligibles. Three states, Kentucky, Nebraska, and Oklahoma, had a decrease in the number of claims received.

TABLE III

THE OVERALL ADMINISTRATIVE COSTS OF MEDICAL ASSISTANCE PROGRAMS AS A PERCENT OF TOTAL PROGRAM COSTS BY STATE

State	*Percent Administrative Cost*
Alabama	3.0
Alaska[1]	7.0
California	6.8
Colorado	4.9
Florida	3.0
Georgia	—
Guam	4.0
Hawaii	5.0
Illinois	—
Kentucky	5.0
Louisiana	1.8
Maryland	2.0
Michigan	2.0
Minnesota	4.0
MISSISSIPPI	3.8
Montana	4.6
Nebraska	12.8
Nevada	7.9
New Hampshire	5.9
New Jersey	4.1
New Mexico	7.4
New York	3.2
North Dakota	2.7
Ohio	2.0
Oklahoma	2.0
Oregon	6.4
Puerto Rico	4.5
South Carolina	5.1
South Dakota	0.1
Texas	3.3
Utah	10.0
Virginia	3.0
Washington	3.6
Wisconsin	3.5
Mean	4.5
Median	3.9

[1] Administrative cost of the Medicaid and general relief assistance program.

TABLE IV

PERCENTAGE OF ELIGIBLES UTILIZING PHYSICIAN SERVICES AND AVERAGE NUMBER OF PHYSICIAN VISITS PER RECIPIENT

State	*% of Eligibles Utilizing Physician Services*	*Average Number of Physician Visits per Recipient*
Alabama	30.0	3.5
Alaska	—	—
California	—	3.4
Colorado	96.4	9.2
Florida	27.6	1.6
Georgia	2.0	0.6
Guam	40.0	2.0
Hawaii	75.0	6.0
Illinois	75.0	4.4
Kentucky	59.8	4.7
Louisiana	24.6	1.1
Maryland	61.6	3.5
Michigan	76.3	15.0
Minnesota	57.9	8.8
MISSISSIPPI	68.6	9.7
Montana	41.3	5.4
Nebraska	68.7	9.1
Nevada	76.3	3.3
New Hampshire	57.0	4.4
New Jersey	43.0	4.5
New Mexico	49.9	5.7
New York	62.9	4.4
North Dakota	75.5	4.2
Ohio	55.0	1.2
Oklahoma	88.0	—
Oregon	17.8	2.0
Puerto Rico	79.7	2.5
South Carolina	42.9	7.1
South Dakota	38.4	9.0
Texas	61.0	9.3
Utah	—	—
Virginia	46.4	4.4
Washington	39.4	5.3
Wisconsin	47.7	8.2
Mean	54.4	5.3
Median	57.0	4.4

Table III indicates the overall administrative costs of medical assistance programs as a percentage of total program costs. Mississippi's cost of 3.8 per cent compares favorably with the national average of 4.5 per cent and median value of 3.9 per cent.

Table IV relates to the utilization of physician services. Sixty-eight per cent of those persons eligible for medical assistance in Mississippi utilized physician services with an average of 9.7 physician visits

per recipient. Both of these figures are well above the national mean and median values.

Table V explores the area of prescription drug utilization. Seventy-one per cent of those persons eligible for medical assistance in Mississippi received prescription drugs with an average of 14.8 prescriptions per recipient. As with physician services, both of these figures are well above the national mean and median values. Cause and effect relationships have not been documented though it has been hypothesized that high drug utilization per recipient in the state may be attributable to a larger ratio of general practitioners to specialists and that collectively general practitioners see patients more often and write more prescriptions than do specialists. Another hypothesis relates to the socioeconomic status of the people in the South. Lower income families tend to be ill more frequently as a by-product of their environment and health practices.

TABLE V

PERCENTAGE OF ELIGIBLES RECEIVING PRESCRIPTION DRUGS AND AVERAGE NUMBER OF PRESCRIPTIONS RECEIVED PER RECIPIENT

State	*% of Eligibles Receiving Prescription Drugs*	*Average Number of Prescriptions Received per Recipient*
Alabama	67.0	3.0
Alaska	—	—
California	—	7.1
Colorado	95.2	10.0
Florida	44.3	8.3
Georgia	70.0	6.1
Guam	—	—
Hawaii	—	—
Illinois	66.0	1.2
Kentucky	29.6	15.3
Louisiana	28.0	5.2
Maryland	69.0	10.8
Michigan	67.4	13.0
Minnesota	55.9	15.1
MISSISSIPPI	71.0	14.8
Montana	37.7	9.0
Nebraska	71.6	13.7
Nevada	72.7	7.4
New Hampshire	51.0	7.7
New Jersey	24.0	21.5
New Mexico	52.3	9.1
New York	66.4	7.4
North Dakota	67.8	11.9
Ohio	55.0	4.2
Oklahoma	—	—
Oregon	18.4	—
Puerto Rico	75.7	2.4
South Carolina	40.2	12.3
South Dakota	—	—
Texas	43.3	13.4
Utah	23.0	—
Virginia	51.6	6.0
Washington	33.3	9.2
Wisconsin	41.8	12.3
Mean	53.2	9.3
Median	53.7	9.0

Table VI presents the percentage of total program expenditures for various types of services. Five of the services are included because they are required to be covered in all states under the Title XIX law. Drugs and Buy-in, Part B, Medicare, two optional services, are included because each represents a significant portion of the Mississippi program expenditures.

The percentages of total program expenditures on both inpatient hospital and skilled nursing home services in Mississippi were lower than the national mean and median. These figures probably do not reflect less utilization of these services but rather that these services are less expensive in a predominantly rural area relative to fees for the other services. Table VII lends further support to this theory as the $9.27 average per capita cost per day for skilled nursing home service in Mississippi was well below the national average.

The percentages of program expenditures for outpatient hospital and laboratory x-ray services were likewise below national figures.

The percentages of total program expenditures made on physician services, 18.4 per cent, and pharmacy services (drugs), 20.8 per cent, are well above the national values. These figures closely relate to the high utilization of these services discussed earlier. It is noteworthy that the rural areas, Puerto Rico, New Hampshire, Oregon, Kentucky, and Mississippi, comprise the leading states in expenditures for both services. It has been documented that a greater percentage of general practitioners are located in the rural areas as compared to urban regions. Once again we are back to the premise that increased utilization in certain locales may be a function of concentration of physician specialty.

Since many states have implemented drug formularies, each director was requested to list the 10 leading drugs by dollar expenditures during the most recent program year. Eighteen states responded and the results are presented in Table VIII.

These data are broken down by state in Table IX.

TABLE VI

PERCENTAGE OF EXPENDITURES FOR MEDICAL SERVICES BY STATE

State	*Hospital Inpatient*	*Hospital Outpatient*	*Laboratory & X-ray*	*Skilled Nursing Home*	*Physician*	*Drugs*	*Buy-in Part B Medicare*
Alabama	20.0	2.1	0.7	26.8	16.6	11.3	10.8
Alaska	19.5	2.2	0.2	53.7	17.5	—	0.0
California	38.5	6.5	0.6[1]	19.2	16.1	6.2	2.2
Colorado	22.6	3.0	1.5	44.8	10.4	10.3	3.4
Florida	24.0	4.0	0.2	37.0	6.0	12.0	5.0
Georgia	25.0	4.0	—	35.0	17.0	10.0	5.0
Guam	58.0	15.0	2.0	—	15.0	5.0	5.0
Hawaii	24.8	5.2	1.4	36.7	17.9	4.9	—
Illinois	32.2	2.5	0.5	3.8	10.2	8.6	0.5
Kentucky	30.4	2.9	0.1[1]	20.0	15.5	15.5	5.1
Louisiana	27.9	2.7	—	43.4	7.3	12.5	—
Maryland	47.2	11.9	0.1	15.3	8.4	10.4	1.5
Michigan	35.7	3.8	0.2	34.5	16.7	8.0	0.6
Minnesota	29.1	3.1	0.5	30.0	12.2	10.5	0.1
MISSISSIPPI	24.3	1.7	0.1	21.5	18.4	20.8	11.2
Montana	22.9	2.3	0.6	28.6	15.6	7.0	2.4
Nebraska	20.1	2.8	1.6	9.8	8.2	8.8	1.0
Nevada	30.3	5.8	0.4	23.9	15.5	7.5	2.1
New Hampshire	34.5	3.3	1.3	6.1	21.7	15.6	2.8
New Jersey	24.0	7.0	0.3	30.0	12.0	6.0	1.1
New Mexico	29.5	2.8	2.5	8.7	15.4	12.7	3.7
New York	49.1	8.1	—	17.7	5.7	3.8	—
North Dakota	27.7	0.9	1.5	39.6	11.9	10.9	0.2
Ohio	31.0	4.0	0.0	20.0	5.0	10.0	2.0
Oklahoma	25.7	0.5	1.0	49.6	15.1	0.1	4.1
Oregon	49.3	7.1	4.4	4.4	20.3	14.5	0.0
Puerto Rico	30.3	18.2	4.5	—	25.5	20.3	—
South Carolina	25.9	2.7	0.1	32.0	16.4	11.5	2.4
South Dakota	20.7	1.4	—	44.1	10.6	—	21.1
Texas	19.2	1.9	1.9	8.0	13.5	8.2	5.0
Utah	27.0	6.0	—	11.0	8.0	8.0	1.0
Virginia	29.8	6.5	0.0	2.7	16.4	11.2	2.8
Washington	28.2	2.6	1.4	35.2	15.6	6.3	2.2
Wisconsin	21.2	2.5	—	50.5[2]	11.8	5.8	0.3
Mean	29.6	4.6	1.1	26.4	13.8	9.8	3.5
Median	27.35	2.95	0.6	27.7	15.25	10.0	2.3

[1] Includes only those claims billed by independent laboratories.
[2] Includes institutions for mentally retarded.

Two antibacterial agents, two minor tranquilizers, and one agent from each of the following therapeutic categories: analgesic, antiarthritic, antihypertensive, antipsychotic, diuretic and hypoglycemic comprise the most frequently utilized drugs. Four of these drugs, Indocin, Orinase, Ampicillin, and Tetracycline, are among the top 10 most utilized drugs in Mississippi. The most utilized drug, Valium, together with the fourth and eighth most utilized drugs, Darvon and Librium, was not covered in the Mississippi Medicaid Drug Formulary during the study period, fiscal year 1972. Darvon Plain 65 has since been reinstated into the formulary on Oct. 25, 1973, under its generic name, propoxyphene HCl caps (plain) 65 mg.

While this survey is not exhaustive in content, it is presented to provide Mississippi practitioners with some comparative data of their Medicaid program.

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School of Pharmacy (38677)

TABLE VII

AVERAGE PER CAPITA COSTS PER DAY FOR SKILLED NURSING HOME SERVICE

State	
Alabama	12.25
Alaska	31.40
California	10.42
Colorado	9.64
Florida	8.86
Georgia	9.86
Guam	—
Hawaii	26.62
Illinois	16.25
Kentucky	15.72
Louisiana	9.03
Maryland	13.58
Michigan	15.03
Minnesota	9.85
MISSISSIPPI	9.27
Montana	10.44
Nebraska	9.22
Nevada	17.20
New Hampshire	21.13
New Jersey	20.94
New Mexico	13.97
New York	41.49
North Dakota	10.10
Ohio	11.20
Oklahoma	—
Oregon	7.91
Puerto Rico	—
South Carolina	16.62
South Dakota	7.90
Texas	11.76
Utah	15.80
Virginia	21.80
Washington	8.02
Wisconsin	14.15
Mean	14.76
Median	12.25

TABLE VIII

TEN MOST FREQUENTLY UTILIZED DRUGS BY EXPENDITURE DURING THE LAST FISCAL YEAR FOR WHICH DATA WERE AVAILABLE

1. Valium
2. Lasix
3. Indocin
4. Darvon
5. Orinase
6. Ampicillin
7. Mellaril
8. Librium
9. Aldomet
10. Tetracycline

TABLE IX

TEN LEADING DRUGS BY EXPENDITURE FOR THE LAST FISCAL YEAR IN DECREASING ORDER OF UTILIZATION BY STATE

Alabama	*California*	*Florida*
1. Ser Ap Es	APC with Codeine ½ gr.	Valium 5 mg.
2. Lasix	Tetracycline 250 mg.	Darvon Compound 65
3. Orinase	Hydrodiuril 50 mg.	Lanoxin 0.25 mg.
4. Salutensin	Lasix 40 mg.	Lasix 40 mg.
5. Lanoxin	Aldomet 250 mg.	Librium 10 mg.
6. Butazolidin Alka	Mellaril 25 mg.	Indocin 25 mg.
7. Diabinese	Erythromycin 250 mg.	Digoxin 0.25 mg.
8. Aldomet	Orinase 500 mg.	Aldomet 250 mg.
9. Aldoril—25	Indocin 25 mg.	Ser Ap Es
10. Dyazide	Valium 5 mg.	Diabinese 250 mg.
Georgia	*Illinois*	*Kentucky*
1. Diazepam 5 mg.	Valium	d-Propoxyphene cpd 65
2. Indomethacin 25 mg.	Ampicillin	Cough Mixtures
3. APC with Codeine ½ gr.	Darvon Compound	Liquid Antacids
4. Furosemide 40 mg.	Librium	Ampicillin 250 mg.
5. Hydergine	Dermatological Prep.	Indomethacin
6. Digoxin 0.25 mg.	Vibramycin	Thioridazine 25 mg.
7. Tetracycline 250 mg.	National Formulary items	Tetracycline
8. Thioridazine 25 mg.	Vitamin Prep.	Hydrochlorothiazide & Reserpine
9. Ampicillin 250 mg.	Mellaril	Steroid-Antibiotic Topical
10. Phenylbutazone 100 mg.	Erythromycin	Hydrochlorothiazide 50 mg.

Louisiana
1. Cyclospasmol 200
2. Lasix 40
3. Ser Ap Es
4. Orinase 500
5. Aldomet 250
6. DBI-TD-50
7. Diabinese 250
8. Hydergine
9. Peritrate SA
10. Pavabid

MISSISSIPPI[2]
Indocin 250 mg.
Aluminum and Magnesium Hydroxide Gel Suspension
Tetracycline 250 mg.
Ampicillin 250 mg.
Erythromycin 250 mg.
DBI-TD
Orinase
Aldoril 25
Ser Ap Es
Arlidin
Keflex

Nebraska
Dyazide
Valium 5 mg.
Darvon Compound 65
Mellaril 25 mg.
Indocin 25 mg.
Pavabid
Aldactazide
Lasix
Peri Colace
Maalox Liquid

New Jersey[1]
1. Valium
2. Darvon Compound
3. Polycillin
4. Librium
5. Mellaril
6. Phenergan Expectorant
7. Lasix
8. Principen
9. Erythrocin
10. Vibramycin

New Mexico
Valium 5 mg.
Darvon Compound 65
Indocin 25
Librium 10
Vibramycin 100
Orinase
Norgesic
Pavabid
Keflex 250
Lasix 40

New York
Ampicillin 25
Benylin Expectorant
Darvon
Diural 500
Librium 10
Maalox Liquid
Orinase Tabs
Periactin Tabs
Valium 5
Donnatal Liquid

Ohio
1. Darvon Compound 65
2. Librium 10
3. Valium 5
4. Pavabid
5. Orinase 500
6. Lasix
7. Indocin
8. Mellaril
9. Darvon 65 mg.
10. Aldomet 250

Oregon
Tetracycline
Ampicillin
Phenobarbital
Penicillin G Potassium
Prednisone
Meprobamate
Digoxin
Erythromycin
Nitroglycerin
Paregoric

Puerto Rico
Aldomet 250 mg.
Diabinese 250 mg.
DBI-TD 50 mg.
Ampicillin Ampules
Insulin Ampules
Mol Iron
Phenformin HCL 50 mg.
Parenteral Solutions
Keflin Ampules

Texas[1]
1. Pavabid Caps
2. Valium 5
3. Indocin 25
4. Lasix 40
5. Ser Ap Es
6. Darvon Compound 65
7. Hydergine Sub. 0.5 mg.
8. Orinase 500
9. Mellaril 25
10. Aldomet 250

Virginia
Darvon Compound 65 Caps
Valium 5
Lanoxin 0.25
Lasix 40
Librium 10 Caps
Darvon 65 Caps
Indocin 25
Orinase 500
Benylin Expectorant
Hydrodiuril

Washington
Theobromine
Antihistamines
Antiarthritics
Ampicillins
Contraceptive Agents
Analgesics and Narcotics
Bronchodilators & Decongestants
Oral Antidiabetic Agents
Topical Corticoid Preps.
Antihypertensives

[1] Based upon one month's data.
[2] Represents a close approximation of the leading drugs by expenditure.

Radiologic Seminar CXXXX: Acro-Osteolysis: A Case Report

JAMES T. TRAPP, M.D., F. L. LUMMUS, M.D.
and B. M. HILBUN, M.D.
Tupelo, Mississippi

A 31-YEAR-OLD Caucasian male was admitted to the North Mississippi Medical Center with the chief complaint of clubbing of the first three fingers of each hand. The patient had noted the onset of this change with progressive severity over the past one and one-half years prior to his admission. In recent months this had also been associated with Raynaud's phenomenon. The patient was a smoker but was not hypertensive and did not exhibit any skin lesions or bleeding tendencies. The patient was employed by an industrial chemical company. His pulmonary function studies were normal as were his serum electrophoresis, T-4, BUN, glucose, electrolytes, urinalysis, SED rate. His serum was positive for cold agglutinins 1 to 64. An upper G.I. series, barium swallow, brain scan, chest x-ray, and x-rays of the skull were all normal. X-rays of the patient's hands showed a peculiar partial dissolution of the distal phalanges of the first three fingers of each hand. The pattern was especially remarkable in that the terminal tufts of the distal phalanges were relatively spared as compared to the distal shaft of the distal phalanges. No soft tissue calcifications were demonstrated, and there was no calcification of any peripheral nerves. Bilateral brachial arteriograms revealed non-specific vasospastic small artery changes associated with an increase in circulation time. No other bony abnormalities were demonstrated in the patient.



Figure 1. A film of the right hand demonstrating an unusual pattern of dissolution of the terminal phalanges of the first three fingers. Changes seen in the right fifth finger are the result of an old injury to the distal phalanx of that finger.

Upon specific questioning of the patient concerning his occupation, it was discovered that the patient did, in the course of his job, daily handle vinyl chloride in small concentrations. Vinyl chloride in an industrial setting has been described to be associated with an almost unique pattern of dissolution of the terminal phalanges of the hands and of the sacro-iliac joints. This has also been noted to be associated with pseudo clubbing of the fingers and

Sponsored by the Mississippi Radiological Society.
From the Departments of Radiology, Medicine and Surgery, North Mississippi Medical Center, Tupelo, Miss.



Figure 2. Films of the left hand demonstrate identical bony lesions involving the distal phalanges of the first three fingers.



Figure 3. A film of the left brachial arteriogram showing non-specific small vessel vasospastic changes which were also associated with increase in circulation time.

with Raynaud's phenomenon. The English literature first reported this phenomen in association with individuals who cleaned polymerization autoclaves utilized in the production of vinyl chloride. The exact mechanism of action is uncertain. Some have suggested that the previously reported cases may represent coincidental scleroderma. Some individuals exposed to vinyl chloride have shown skin lesions in addition to the bony changes as described. It would appear, however, that the bony lesions associated with vinyl chloride exposure are radiologically distinct from those present in scleroderma, and pathologists have felt that it is generally possible to distinguish the skin lesions of vinyl chloride exposure from those which occur in scleroderma. Also of note is the fact that withdrawal from exposure to vinyl chloride has been associated with healing of the bony lesions of the terminal phalanges and sacroiliac joints.

The differential diagnosis of acro-osteolysis would include scleroderma, dermatomyositis, sarcoidosis, leprosy, frost bite, electrical injury, radiation injury, severe primary or secondary small vessel vasospastic disease, and possibly hyperparathyroidism. Classically, this type of distal phalanx resorption has been associated with scleroderma. There is little in the present case to indicate the diagnosis of scleroderma or other collagen diseases as the underlying etiology. The absence of soft tissue calcification virtually excludes scleroderma. There is nothing in the clinical complex in this man to suggest any of the other differential possibilities mentioned above. For these reasons, and because of the unique pattern of acro-osteolysis present here and the historical correlation with vinyl chloride exposure, we feel that this young man represents another instance of acro-osteolysis occurring as the result of industrial vinyl chloride exposure. It is our plan to obtain periodic radiographs of the hands in this man after he has been removed from contact with vinyl chloride in an effort to document healing of the osseous lesions. If

healing is demonstrated the diagnosis is reasonably well established.

Vinyl chloride exposure in an industrial setting is another etiology for dissolution of the distal phalanges. The fact that these lesions are reversible when exposure to vinyl chloride is terminated makes them somewhat unusual. Associated findings include Raynaud's phenomenon and pseudo clubbing as well as erosion of the sacro-iliac joints. It would appear radiologically that the lesions are unique. These bony lesions also occur in the absence of other associated radiographic findings which are a part of this picture of other clinical syndromes commonly responsible for such bony changes. It would appear from this case that exposure to high concentrations of vinyl chloride is not necessary to produce the bone lesions, since this individual's contact was with low concentrations of the chemical. ★★★

835 Gloster Street (38801)

REFERENCES

1. Gondos, B.: Roentgen Manifestations in Progressive Systemic Sclerosis. Am. J. Roentgenol. 84:235-247, 1960.
2. Harris, D. K. and Adams, W. G. F.: Acro-Osteolysis in Men Engaged in the Polymerization of Vinyl Chloride. Brit. Med. J. 3:712-714, 1967.
3. Jacobson, H. G. et al: Bone Disease Syllabus (Disorders of the Skeleton). Am. Col. Radiology, pp. 154-166, 1972.

"Doctor, what should a man take when he is run down?"
"The license number, sir, the license number."

"My wife has the worst memory I ever heard of."
"Forgets everything, eh?"
"No, remembers everything."

Where to Put the Telephones And How to Best Utilize Them

GEORGE S. CONOMIKES
Greenwich, Conn.

SINCE THE Watergate escapades, one tends to hesitate calling himself an expert on telephone equipment. However, here are some ideas on telephone equipment and how to use it better.

1. Phones in exam rooms. Although many have phones in their exam rooms, our studies have shown that they invite interruptions to the physician. Most physicians and their patients do *not* like to be interrupted in the course of a patient examination visit.

Emergencies and calls for physicians can be handled by girls out at the nearby nurses' station, which also affords more privacy.

2. Wall mounting of phones. This is a good idea, especially in the reception area, the nurses' station, and the lab.

Many physicians have wall-mounted phones in their offices as well. This keeps work areas open for work, whereas tabletop phones get in the way.

3. Patients—should they use phones? If patients are kept waiting very long, it may be important for them to be able to call their homes or offices because their plans may be affected.

Most offices provide a phone to patients without charge. Some busy group practices employ a separate handset at the reception desk for such purposes.

Some practices, if this courtesy has been abused, have put a pay phone (wall-mounted) in the reception area or hallway outside the reception area.

4. Special lines. In large practices, it is sometimes a good idea to have a special separate phone number for the appointment secretary. This can reduce the incoming phone load on the telephone receptionist.

5. Intercom. The phone system in your office could be designed to have an intercom capacity. In designing this system, make sure that you do not go overboard. Remember, every wire, buzz, and flashing light for each location costs you money each month.

6. Leasing phone equipment. Within the past years, we have witnessed a new capability—buying or leasing equipment from a private phone company.

Your local phone company still provides you the phone lines; however, you may want to analyze whether to lease or buy your equipment. Most contracts we have seen make it possible for you to own your phone equipment outright in about 4-5 years.

Companies engaged in this field are the Arcata and Litton Phone Systems. They have a unique piece of equipment that you can't get from the Bell System companies—a 12-line system that is especially good for a 5- to 10-man group.

These private phone companies are now located in the top 30-70 cities in the United States. Be sure to find out how good their service is before you leap.

7. Star-set. A unique space-age phone is a wire-like unit weighing only about 11 ounces, which your phone receptionist should like.

Called the Star-set, it fits over the ear and has a thin wire curving around to almost an inch in front of the mouth. It is light, cosmetically acceptable since it doesn't touch the hair (no head-clamp), and leaves both hands free for writing, filing, etc.

We have also found that it reduces the noise level since conversation can be carried on at a normal level.

Star-sets usually rent for about $4-5 per month and installation is about $10.00. Ask your phone representative.

8. Phone-answering equipment. Most physicians who have used phone-answering devices have stopped using them.

Their patients complain—some don't comprehend the message, and it is very impersonal.

Phone-answering services seem to do a better job, even when they aren't too good.

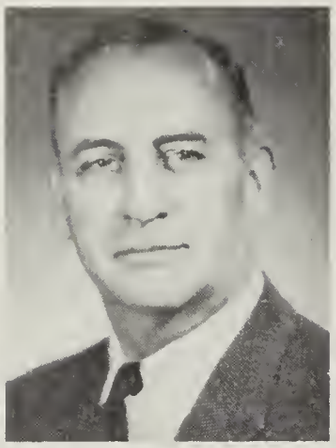
9. Phone-answering services. The best ones seem to be those run by local medical societies or those that are cooperatively owned by a group of doctors in a community.

A phone-answering service should be recognized as risky, irritating to the patient and to the physician. We feel that more physicians and medical societies should be developing better medical phone-answering services.

The next column will be devoted to more time-savers for the physician. ★★★

64 Greenwich Ave. (06830)

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The President Speaking

A Consensus of Opinion

J. T. DAVIS, M.D.
Corinth, Mississippi

THE RECENT 106th Annual Session will no doubt become one of the most important in the 118 years of our Mississippi State Medical Association. There were many decisions made by the House of Delegates that represent a "crossroads" for our profession. The delegates expressed and discussed numerous viewpoints before a consensus was reached and this is as it should be because the House represents the democratic process at its best. There we had elected representatives from all areas of the state chosen by their local colleagues. Many came representing a viewpoint based on concerted action by their component society. All came with the best interests of our profession at heart.

The issues were many to include PSRO, reapportionment of association districts, and the future of the Mississippi Foundation for Medical Care. The House of Delegates held its opening meeting the morning of May 6 and received reports and resolutions. That afternoon the reference committees of the House met. All business before the House is referred to a reference committee. Any member of the association may appear before these committees and express his views. The reference committees then attempt to arrive at a consensus of viewpoints for a final decision by the House.

This year's reference committees were especially well attended as reflected by the discussion on PSRO which lasted some 2½ hours and included every thought on PSRO ever heard or read by this writer. The discussion even included the president of the American Medical Association, Dr. Russell B. Roth, whom we were pleased to have attend our meeting and address both the House of Delegates and reference committee handling PSRO.

The decisions of our elected representatives are best reflected in the "Transactions of the House of Delegates" to be published in the August JOURNAL MSMA and reported by the delegates to their local colleagues. The issues were heavy! The "consensus" was obtained after much thought and hard work by many. I will be counting on each you to help me carry out the decisions of the House during the coming year! ★★★

JOURNAL OF THE
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EDITORIALS

MPAC and State Politics

During the association's recent 106th Annual Session the House of Delegates adopted a recommendation from the Council on Legislation authorizing the Mississippi Medical Political Action Committee (MPAC) to expand its activities to our own state legislative elections beginning in 1975. For many years now our PAC, unlike those in other states, has confined its involvement to U. S. Congressional races and by so doing, we have relegated the participation of organized medicine in our statewide electoral process to a hands-off, take-what-you-get position. The time for that laissez-faire approach, as expressed by your approval of the Council's recommendation, has passed, and hopefully its passage has marked the beginning of an era in which medicine will work to guarantee the enactment of sound and constructive health legislation through an active participation in the process of selecting those individuals who will ultimately decide what legislation will be passed.

Now we must ask ourselves certain questions. How successful can we be in influencing the outcome of elections? To what extent and how will MPAC extend its involvement to legislative races on the local level? How does this whole process help assure the passage of good, as well as the elimination of poor, legislation?

The answer to the first of these questions is simple—we can be as effective as we want to be. Our effectiveness will depend to a great extent on our willingness to get involved in the electoral, and thus, political process. Unfortunately, an involvement of this type is something that many physicians, for various reasons, have an aversion to. It has been said that people rightfully expect a physician to be skilled in medicine and healing, a lawyer to be expert in laws and jurisprudence, but that these same people have an abhorrence for one who is involved in politics being a politician. Whatever our feelings about the integrity, or lack thereof, of politics and politicians, if we are to fulfill our responsibility in guarding the health of the public we must have a strong and active voice in the electoral process. In today's society, politics cannot be separated from government. To have a voice in government, political activity is necessary. Are we really fulfilling our responsibility as physicians if we do all in our power to cure our patients from their real or imagined ills and, at the same time, stand idly by while the acknowledged foes of scientific medicine remain in or get elected to public office? Call it preventive medicine, preventive politics or whatever; irregardless of its name, it's something we must begin doing. If we make this total commitment to get involved at every level of the electoral and legislative process the medical profession can have a singularly definitive effect on that process. No person or group is in a better position or is better able to influence the outcome of elective campaigns than the physician. This is true not only because, as a recent poll shows, physicians are trusted more by the public than any other profession, but also because no one has more personal contact with the public on a day to day basis than the medical profession. How many voters in your community do you think you could influence if you took an open, public stand behind a particular candidate? How many times have aspiring candidates for public office contacted you personally to

request your support? It's ironic that almost everyone else recognizes this great reservoir of influence the medical profession has at its disposal except we physicians. The time has come for organized medicine to exercise this wealth of influence in helping assure the quality of state government.

The answer to the second question—how will MPAC extend its activities to local campaigns—can be found in a review of the methodology employed by other state political action committees. The formula is as simple as it is successful. Your MPAC board will not decide which candidates to support; this will be left up to you—the physicians on the local level. Physicians and their wives in an electoral district should get together for the purpose of discussing and reviewing the qualifications, voting records, and positions of all the candidates and then decide upon the one they intend to support. They should then assist the candidate in his campaign efforts by supporting him publicly, eliciting local voter support, helping to raise campaign funds and by holding meetings with the voters so that the candidate can express his views on all the issues. MPAC will lend its support in the following manner: whatever funds are contributed to the campaign by physicians on the local level will be matched by MPAC. In addition, the MPAC staff will lend its assistance in helping organize the local "Candidate Support Committee" in its activities. The success and influence of such support committees has been proven countless times, as numerous congressmen and legislators will themselves testify.

There are essentially two predominate methods for affecting the passage of legislation. The first of these methods is participation in the electoral process, since the type of legislation which becomes law is directly related to the types and kinds of elected officials who ultimately decide, through their votes, what should or should not become law. The second method entails what is commonly known as "lobbying," or, constant communication with elected officials on the need for and merits of a particular piece of legislation. Both of these activities are so tightly interwoven and interdependent on each other in the legislative process that the absence of one without involvement in the other seriously detracts from the ultimate effect of either. Stated differently, once you've got the right person elected, you've got to keep him informed.

Throughout the years many of us have contributed money to various legislative campaigns, but all too often that has been the extent of our involvement. Although money is a necessary part of any election it will not in and of itself decide the outcome. Elections are won by votes, and these votes are won by the hard work and active participation of many people. Through active participation we, as physicians, can effectively contribute toward assuring that there will be an open channel between medicine and government whenever legislation is being considered that will affect the profession or the health of the public.

The future course of MPAC has been charted, but only you can determine the successful end of its journey. Only 50 percent of the total association membership belongs to MPAC. When you consider the fact that every automobile worker contributes 50 dollars a year for political activities, a $10 Regular Membership or even a $99 Sustaining Membership in MPAC seems little to ask of a profession that is continuously feeling the ever-increasing shadow of government.

The alternative to our participation is simple: give the quack a free ticket to anything he wants, at the expense of our profession and the public.

JAMES O. GILMORE, Chairman
Board of Trustees



"You caught up with your insurance work!"

Medico-Legal Briefs

PHARMACISTS MAY FILL OUT-OF-STATE PHYSICIANS' DRUG PRESCRIPTIONS

Prescriptions from out-of-state physicians registered under the Federal Controlled Substances Act but not registered in the state may be filled by duly authorized Iowa pharmacists, the Iowa Supreme Court ruled. Out-of-state physicians could not be required to register in Iowa as a prerequisite to having their prescriptions filled by local pharmacists.

At the behest of the Iowa Board of Pharmacy Examiners, the State Attorney General filed a petition seeking a permanent injunction against a pharmacy to prevent them from filling prescriptions written by nonresident physicians not licensed by state authorities to prescribe controlled substances.

The pharmacy received prescriptions by mail, filled them, and returned them by mail. Some of them were written by nonresident physicians not registered to prescribe controlled substances by the Iowa Board. The Iowa Uniform Controlled Substances Act prohibited state pharmacists from filling prescriptions written by Iowa physicians who were not thus registered.

The trial court found that the Iowa Act was intended to regulate only intrastate controlled substances transactions and that nonresident physicians registered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 were considered to have complied with the Iowa Act.

The court found that the federal act permitted Iowa pharmacists to dispense drugs on prescriptions of practitioners licensed by the jurisdiction in which they practiced. The court also held that filling prescriptions in Iowa of physicians licensed in other states constituted interstate commerce.

The trial court further concluded that requiring all out-of-state physicians to register in Iowa before they could prescribe drugs for Iowa residents to be obtained from Iowa pharmacists would place an unreasonable burden on interstate commerce. The court said that the state had the right to regulate medical licensing within its borders but not to require nonresident physicians to register in Iowa.

On appeal, the court said that it was reasonable to interpret the Iowa Act to apply only to resident physicians. The court felt that such interpretation would insure continued free movement of controlled substances between states while securing them against drug diversion from legitimate sources.

The state contended that filling of prescriptions by out-of-state physicians constituted the practice of medicine in Iowa and that the state could not be certain that such physicians were competent to prescribe such drugs. The state further argued that a nonresident physician could comply with the Iowa Act simply by registering in Iowa.

The Supreme Court said that such registration requirement would negate operation of the federal act in the state. The court pointed out the licenses were issued by the federal authority for the purposes of federal legislation controlling drug abuse. Affirming the trial court ruling, the court found that such interest clearly outweighed any local interest in allowing only state-registered physicians to prescribe in the state.—*State of Iowa v. Rasmussen,* 213 N.W. 2d 661 (Iowa Sup.Ct., Dec. 19, 1973)



No deaths were reported this month.



SIRS: Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the Imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the type of reaction and complications, if any, the age, sex, and race of the patient, the site of the bite(s), the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to me at the following address—

CLAUDE A. FRAZIER, M.D.
4-C Doctor's Park
Asheville, NC 28801

NEW MEMBERS

BARNES, HELEN BEATRICE, Jackson. Born Jackson, Miss., Dec. 9, 1928; M.D., Howard University College of Medicine, Washington, D. C., 1958; interned Kings County Hospital, Brooklyn, N. Y., one year; ob-gyn residency, same, 1959-1960 and 1963-1965; elected by Central Medical Society.

BOURGEOIS, MICHAEL O., Biloxi. Born Morganza, La., Jan. 4, 1945; M.D., Louisiana State University School of Medicine, New Orleans, La., 1969; interned USPHS, New Orleans, 1969-70; ob-gyn residency, USPHS, New Orleans, 1970-73; elected by Coast Counties Medical Society.

BRADFORD, BERT EDWIN, McComb. Born Columbia, Miss., July 23, 1942; M.D., University of Mississippi School of Medicine, 1968; interned, same, one year; pediatric residency, same, 1969-71; elected by South Central Medical Society.

BUSH, CHARLES A., Waynesboro. Born Laurel, Miss., Oct. 14, 1945; M.D., University of Mississippi School of Medicine, 1970; interned Mississippi Baptist Hospital, one year; elected by South Mississippi Medical Society.

BYARLAY, JOHN WILLIAM, Corinth. Born Little Rock, Ark., Feb. 4, 1942; M.D., University of Arkansas School of Medicine, Little Rock, Ark., 1968; interned John Peter Smith Hospital, Ft. Worth, Tex., one year; elected by Northeast Mississippi Medical Society.

CALDWELL, DELMAR, Jackson. Born Putnam, Okla., Oct. 29, 1935; M.D., University of Oklahoma School of Medicine, Oklahoma City, Okla., 1961; interned John Seal Hospital, Galveston, Tex., one year; ophthalmology residency, Baylor College of Medicine, Houston, Tex., 1969-72; fellowship, same, 1972-73; elected by Central Medical Society.

CAREY, FLOYD T., McComb. Born Richton, Miss., Aug. 12, 1934; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1961; interned Grady Hospital, Atlanta, Ga., one year; pediatric residency, City of Memphis Hospitals, Memphis, Tenn., 1966-67; pediatric residency, University Medical Center, Jackson, Miss., 1969-71; elected by Central Medical Society.

CHAMBERLIN, MARSHALL THOMAS, Hickory Flat. Born Saginaw, Mich., Aug. 6, 1945; M.D., Wayne State University School of Medicine, Detroit, Mich., 1971; interned Robert Packer Hospital, Sayre, Pa., one year; elected by Northeast Mississippi Medical Society.

GABEL, JOSEPH C., Jackson. Born Fremont, Ohio, April 9, 1937; M.D., Ohio State University College of Medicine, Columbus, Ohio, 1964; interned USAF Hospital, Travis AFB, Calif., one year; anesthesiology residency, Wilford Hall USAF Hospital, Lackland AFB, Tex., 1965-67; elected by Central Medical Society.

GREEN, JAMES REED, Meridian. Born Hattiesburg, Miss., Nov. 4, 1942; M.D., University of Mississippi School of Medicine, 1968; interned Mobile General Hospital, Mobile, Ala., one year; orthopaedic surgery residency, University Medical Center, Jackson, Miss., 1969-73; elected by East Mississippi Medical Society.

SMITH, MILTON SHELBY, McComb. Born Liberty, Miss., Oct. 11, 1941; M.D., University of Mississippi School of Medicine, 1966; interned University of Tennessee, City of Memphis Hospitals, one year; pediatric residency, same, 1967-68; pediatric residency, University Medical Center, Jackson, Miss., 1968-69; pediatric fellowship, 1967-69; elected by South Central Medical Society.

WALKER, GEORGE G., Starkville. Born Cumberland, Miss., Nov. 22, 1941; M.D., University of Mississippi School of Medicine, 1966; interned, same, one year; ophthalmology residency, University of Tennessee, Memphis, Tenn., 1970-73; elected by Prairie Medical Society.

WATT, JAMES A., Meridian. Born Salt Lake City, Utah, Feb. 19, 1913; M.D., University of Colorado School of Medicine, Denver, Colo., 1937; interned Methodist Hospital, Memphis, Tenn., one year; pathology residency, same, 1961-63 and 1963-65; residency in pathology, Kennedy V.A. Hospital, Memphis, Tenn., 1963-65; pathology fellowship, University of Tennessee, 1965-66; psychiatry residency, University of Tennessee, Memphis, Tenn., 1970-72; elected by East Mississippi Medical Society.

WILLIAMS, RONALD B., Meridian. Born Meridian, Miss., Mar. 27, 1941; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned Naval Hospital, San Diego, Calif., one year; anesthesiology residency, same, 1967-70; elected by East Mississippi Medical Society.

Book Reviews

Your Personal Learning Plan: A Handbook for Physicians. By Leonard S. Stein, Ph.D. 32 pages. Published by the Illinois Council on Continuing Medical Education, 1973. $1.00.

This monograph is a short syntactic, pragmatic plan to allow a medical intellectual heterosis from available continuing medical education: a simple one, two, three learning methodology that can be individualized; a nudge to develop a disciplined learning system; one that can relate to real needs as well as give a new practice perspective.

The purpose of this publication is to assist a physician to devise a plan for continuing education that fits particular needs, interest, and concerns.

Elements of the suggested plan are:

1. Determine your needs.
2. Assess your practice.
3. Select specific learning objectives, on the basis of the first two steps.
4. Decide how to achieve each learning objective.
5. Inventory learning resources available to you.
6. Decide on priorities and establish a schedule.
7. Evaluate your learning achievement.

Each element is explored in appropriate depth. Informational sources are also provided.

This is the best publication I have seen designed to assist a practicing physician structure an individual continuing educational program.

Though it does not discuss it, this plan relates to a new model of continuing medical education proposed by Dr. George E. Miller, called the "process model" whereby knowledge is acquired in a form more likely to lead to its utilization. In this model learning is accomplished by involving learners in identifying problems and seeking ways to solve them. This is in contrast to the traditional "content acquisition" model which has a primary focus on communication of teacher-selected knowledge.

T. D. Lampton, M.D.
Jackson, Miss.

Annual Review of Allergy, 1973. Edited by Claude Albee Frazier, M.D. 535 pages with illustrations. Flushing, N. Y.: Medical Examination Publishing Company, Inc., 1974. $15.00.

This is the second edition of the *Annual Review of Allergy*. The number of contributors has increased from 28 to 50 and the number of pages has increased from 328 to 535. The 1972 edition covered 20 subjects, while the 1973 edition covers 32 subjects.

Subjects covered in the 32 chapters concerned clinical immunology, autoimmunity, clinical allergy, tumor immunology, transplantation immunology, effect of air pollution and weather on bronchial asthma, drug allergy, dentistry and allergy, and even a chapter on atopy in the canine.

As in the 1972 edition, the chapters are well written, current, and have good clinical information. There is very little duplication of material covered in the 1972 edition, which emphasizes the volume of material published in the rapidly expanding field of clinical immunology and allergy.

While appealing primarily to physicians who regularly treat allergic diseases, many chapters would be of interest to all physicians.

Chapter 13 on "Infiltrative (Hypersensitivity) Lung Disease" is particularly good. It is a thorough review of the recently recognized hypersensitivity lung diseases covering salient clinical and immunological features, as well as treatment. As a bonus, a bibliography of 165 references is given.

Chapter 27 on "Drug Allergies" would appeal to all physicians and is very worthwhile. This is a book that is best "nibbled on" at frequent intervals rather than digested in one sitting. Even though the print is small, this is an excellent and current review of clinical allergy and immunology.

Wilfred Q. Cole, M.D.
Jackson, Miss.

PERSONALS

WILLIAM O. BARNETT of Jackson and UMC met with the American Surgical Association in Denver April 30-May 4.

JOHN BOWER and HERBERT G. LANGFORD of Jackson and UMC were among the guest speakers at the annual meeting of the Mississippi Medical, Dental and Pharmaceutical Association held in Jackson.

RICHARD BURMAN of Gulfport, J. T. DAVIS of Corinth, and HOWARD NELSON of Greenwood were among special guest speakers at the medical assistants state convention held at the Ramada Inn in Greenwood.

M. H. EGYED opens his office at 1011 South Main Street in Newton.

JAMES D. HARDY of Jackson and UMC gave the R. J. White Lecture on management of shock in surgical patients at the meeting of the Fort Worth Surgical Society in May.

MARVIN JETER of Jackson and UMC took a course on the master approach to cardiac emergencies sponsored by the University of Miami School of Medicine in Lake Buena Vista, Fla.

SAMUEL B. JOHNSON of Jackson was named president of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society at the 36th annual session in Biloxi. ARTHUR V. HAYS of Gulfport was re-elected secretary and JOHN WHITE of Jackson was named to the board.

CHARLES WILLIAM KRIEGER JR., announces the opening of his office at 310 N. Main Street in Picayune for the practice of bone and joint surgery.

HENRY LYNCH and HENRY GOODMAN of Rolling Fork are serving on a steering committee to seek additional doctors for Sharkey and Issaquena counties.

WESLEY MCFARLAND, GLENN RICHARDSON and GERALD J. FREDERICK have assumed fulltime positions in the new Emergency Department at Memorial Hospital in Gulfport.

During the annual Doctor's Day observance, friends and patients of WILLIAM B. O'KELLY of Weir honored him with a plaque in appreciation for 20 years of faithful service.

DONALD M. SHERLINE, professor of obstetrics and gynecology, instructor in obsetric anesthesia, and associate chairman of the Department of Obstetrics and Gynecology at the University of Mississippi School of Medicine, has been promoted to assistant professor of anesthesiology (obstetric anesthesia).

VIRGINIA TOLBERT of Ruleville was re-elected president of the Sunflower County Heart Association for 1974-75. Also elected were BEN RADER of Indianola, medical representative; WALTER ROSE of Indianola, CPR; Dr. Tolbert and Dr. Rose, high blood pressure screening; and Dr. Rose, heart fund chairman.

CHARLES T. WEEKS is now associated with the Street Clinic and Mercy Regional Medical Center in Vicksburg for the practice of orthopedic surgery.

W. L. WEEMS of Jackson and UMC was a visiting professor at the University of Cincinnati Medical Center April 7-9.

CHESTER WILLIAMS of Hattiesburg was a guest speaker at the 27th annual Mississippi State Society for Medical Technology held in April at Biloxi.

MEDICAL DIRECTOR

The Board of Trustees, Eleemosynary Institutions is seeking physicians applicants for a fulltime position as medical director at each of the following state operated acute general hospitals: **South Mississippi State Hospital, Laurel; Kuhn Memorial State Hospital, Vicksburg;** and **Natchez Charity Hospital, Natchez.**

There would be no initial cost to the physician for equipment, office expenses, or secretarial expense. Estimated income, $50,000 annually. Physicians interested in these positions should contact the following board members; Joe M. Ross, M.D., The Street Clinic, Vicksburg; J. P. Tatum, M.D., 1314 19th Avenue, Meridian; Charles A. Hollingshead, M.D., 103 S. 12th Avenue, Laurel; John R. Young, M.D., 55 Sergeant Prentiss Dr., Natchez; O. B. Crocker, M.D., Bruce, or the Board's Office, 1404 Woolfolk State Office Building, Jackson, Mississippi 39201.

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

June3-June 16

Good Tennis Is Good Medicine, with Robert Nirschl, M.D., Chief, Orthopedic Surgery, Northern Virginia Doctors Hospital; Attending Orthopedic Surgeon, Arlington Hospital; Chairman, Committee on Medical Aspects of Sports of the Medical Society of Virginia; Clinical Instructor in Orthopedic Surgery, Georgetown University School of Medicine, Washington, D. C.

Emergency Transvenous Cardiac Pacing, with Doris J. W. Escher, M.D., Attending Physician, Department of Medicine, Cardiology Division; Physician-in-Charge, Cardiac Catheterization Unit, Montefiore Hospital and Medical Center, Bronx, N. Y.

Scanning the Brain in Cross Section, with Paul Frederick New, M.D., Chief of Neuroradiology, Massachusetts General Hospital; and Assistant Professor of Radiology, Harvard Medical School, Mass.

June 17-July 14

Lice, Mites, and Man, with Silas O'Quinn, M.D., Dermatologist and Dean of Medicine; and Harold Trapido, M.D., Professor of Tropical Medicine and Medical Parasitology; both of Louisiana State University Medical Center, New Orleans.

Ultrasonic Imaging: Echoes With Answers, with Barry Goldberg, M.D., Assistant Professor of Radiology, Temple University Health Sciences Center; and Head, Section of Diagnostic Ultrasound, Episcopal Hospital, Philadelphia.

Long-Term Pacemaker Therapy, with Doris J. W. Escher, M.D., Attending Physician, Department of Medicine, Cardiology Division and Physician-In-Charge, Cardiac Catheterization Unit; and Seymour Furman, M.D., Associate Attending Surgeon, Department of Cardiothoracic Surgery; both of Montefiore Hospital and Medical Center, N. Y.

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change)

Premedical Program for Disadvantaged Started

Fifteen high school graduates begin a special premedical program at Millsaps College and the University Medical Center June 3.

Picked for their potential, the 15 will come from "disadvantaged" backgrounds likely to handicap college achievement or discourage medical careers.

A three-year grant from DHEW Bureau of Health Manpower Education to the Medical Center will pay for the pilot program, designed to increase the number of qualified minority or other disadvantaged applicants to medical school.

Anticipated total support is $641,431 with $176,283 awarded for the first year. Dr. Norman C. Nelson, Medical Center vice-chancellor, and Dr. Edward M. Collins, Jr., Millsaps president, announced plans for the joint venture.

After completing a summer of concentrated, individualized study at Millsaps, students who meet entrance requirements at Millsaps will continue as premed college freshmen in the fall. More groups of 15 will enroll in succeeding grant support years.

Project coordinators hope the grant will help keep some of the state's best students from disadvantaged homes in the state for college, medical school, and medical careers.

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Dr. J. T. Davis Is Inaugurated President, Dr. Jack Atkinson Is Named President-elect

Dr. Jack A. Atkinson of Brookhaven was named president-elect of the association at the closing meeting of the 106th Annual Session, and Dr. J. T. Davis of Corinth was inaugurated 1974-75 president, succeeding Dr. Arthur A. Derrick, Jr., of Durant.

The four-day meet was headquartered at the Sheraton-Biloxi and featured meetings of the seven scientific sections, meetings of 15 specialty societies, and medical alumni and social occasions. More than 30 essayists presented a varied program which drew praise of registrants. Many of the scientific presentations will be published in future issues of the JOURNAL.

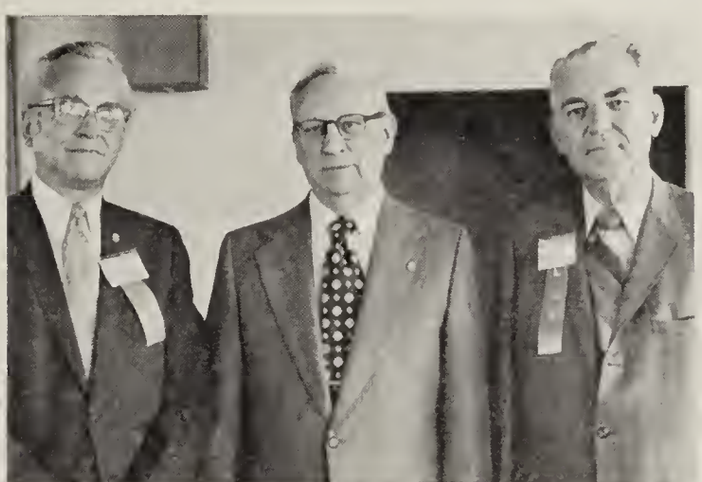
The Coast annual session had a registration of 787 which included 378 members, 50 M.D. guests, 21 interns, residents and students. Others included 30 guests (non M.D.), 108 exhibitors, 193 Auxiliary members, and 7 staff.

Handling a heavy business agenda, the House of Delegates acted on 11 reports, 4 of which were from the Board of Trustees, and 10 resolutions. Four reference committees conducted hearings before which members and guests appeared for discussion and debate.

Dr. Arthur A. Derrick addressed the opening meeting of the House of Delegates on May 6 on the medical manpower shortage, medical politics and MPAC, the quality of health care, the Miss. Foundation for Medical Care and PSRO. The 1973-74 president urged that the profession become more responsive to health service needs and the desires of the American people.

Sharing the rostrum spotlight with Dr. Derrick was Dr. Russell Roth of Erie, Penn., president of the American Medical Association, who discussed PSRO, wage and price controls and the internal situation at the AMA.

Dr. Roth said he thinks no national health insur-



Three years of the association's presidency are represented by, from left, Dr. Arthur A. Derrick, Jr., of Durant, immediate past president, 1973-74; Dr. J. T. Davis of Corinth, newly inaugurated MSMA president, 1974-75; and Dr. Jack A. Atkinson of Brookhaven, the new president-elect, 1975-76.



Dr. Russell Roth of Erie, Penn., president of the American Medical Association, appeared as principal guest speaker of the annual session. He addressed the House of Delegates at the opening meeting.



Past presidents of the association enjoy fraternal and traditional breakfast with special guests, Drs. Derrick and Davis, candidates for select circle. Below, three of the reference committee chairmen report to the House of Delegates at the Thursday afternoon session. From left are: Dr. Walter Rose of Indianola, chairman of the Reference Committee on Medical Practices; Dr. Tom Mitchell of Vicksburg, member of the Council on Constitution and By-Laws who made report in absence of council chairman Dr. Raymond Martin of Jackson; and Dr. Arthur E. Brown of Columbus, chairman of the Nominating Committee.







ance bill will be passed by Congress next year and he called the Kennedy-Mills national health insurance plan "purely a political grandstand play." He added that the proposed program would create a "tremendous, expensive corps of government bureaucrats."

A gift of $9,628.91 was made to the University Medical Center by the state association and auxiliary AMA-ERF campaign.

New vice presidents named to serve in 1974-75 are Drs. Whitman B. Johnson of Clarksdale for the northern area, William B. Hunt of Grenada for the mid-state area, and Paul H. Moore of Pascagoula for the southern area of the state.

Dr. W. Moncure Dabney was re-elected editor of the JOURNAL MSMA and Dr. George H. Martin of Vicksburg was re-elected associate editor.

Dr. Joseph B. Rogers of Oxford was re-elected as delegate to AMA and Dr. Arthur E. Brown of Columbus was re-elected to another term as alternate delegate to the AMA.

Delegates, tallied at 92 in the May 6 balloting, elected Dr. Arthur A. Derrick of Durant District 4 trustee to succeed Dr. Paul B. Brumby of Lexington who withdrew his name from the nominating committee slate. Dr. Joe S. Covington of Meridian was elected District 6 Trustee and Dr. Carl G. Evers of Jackson was re-elected District 5 Trustee.

Elected to the Council on Budget and Finance was Dr. Gerald P. Gable of Hattiesburg.

Dr. W. Lamar Weems of Jackson was elected to the Council on Constitution and By-Laws. Named to the Judicial Council were Dr. Gerald A. Smith of Sumner, District 1; Dr. John R. Lovelace of Batesville, District 2; and Dr. Frank M. Davis of Corinth, District 3.



Dr. Virginia S. Tolbert of Ruleville was 1974 winner of the MSMA-Robins Award for outstanding community service by a physician. President Derrick, left, and Mr. Willard Duval of the A. H. Robins Company, right, made the presentation of the engraved plaque to Dr. Tolbert. She was cited for her work in city government, civil defense, energy conservation and sanitation.

Re-elected to the Council on Legislation was Dr. W. H. Preston, Jr., of Booneville. New members of the council are Drs. James V. Ferguson of Greenwood and David A. Ball of Batesville.

Dr. Carl G. Evers of Jackson was re-elected to the Council on Medical Education while Drs. Ed Pennington of Ackerman, Tom H. Mitchell of Vicks-



Delegates show concentration at closing meeting of the House of Delegates when reports of reference committees were presented for discussion and voting and new officers were elected.



Members of the Fifty Year Club of the association participated in their annual special luncheon meeting in conjunction with the annual session. Club "officers" are Board chairman James O. Gilmore and Mrs. Barbara Shelton, MSMA Membership Director, who serves as club secretary. Below, association members appear before reference committees to discuss the issues. Reference committee meetings shown are Council on Constitution and By-Laws, Reports of Officers and Board of Trustees, and Medical Practices.







burg, and William M. Gillespie, Jr., of Meridian were named to the Council on Medical Service.

The four-day annual meeting was approved for 14 prescribed hours of credit for continuation study requirements by the American Academy of Family Physicians.

Mrs. Dan Reikes of Hattiesburg was inaugurated president of the Woman's Auxiliary to the MSMA in their concurrent annual meeting.

New officers elected by the ladies are Mesdames J. Edward Hill of Hollandale, president-elect; Joe D. Herrington of Natchez, first vice president; Tom Blake of Jackson, second vice president; Patrick Pierce of Gulfport, third vice president; John Green of Hattiesburg, fourth vice president; W. Moncure Dabney of Crystal Springs, treasurer; and William Hilbun of Meridian, secretary.

Specialty Societies Hold Concurrent Meetings

A total of 15 specialty societies and related groups met concurrently with the association during the 106th Annual Session at the Sheraton-Biloxi. Scientific sessions and social occasions drew members of almost every specialty.

Pathologists from throughout the state attended the May 5-6 meetings of the Mississippi Association of Pathologists. Dr. Van Philpot of Houston was named president-elect; Dr. Hollis Burrow of Greenville, president; Dr. Julian C. Henderson of Jackson, secretary; and Dr. Larry Smith of Hattiesburg, treasurer. Dr. George F. Smith of Jackson is immediate past president.

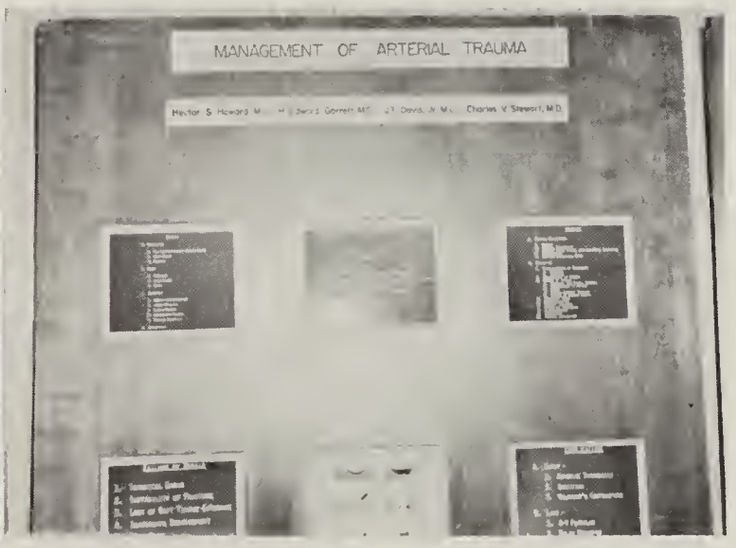
The Mississippi Dermatological Society held its organizational meeting on Sunday, May 5. Officers





Winners of the awards for best scientific exhibits are shown. Top left, "Intestinal Obstruction in Cystic Fibrosis" by Drs. Suzanne T. Miller and Richard C. Miller of the University Medical Center received the first prize Aesculapins Award, an engraved walnut plaque. for best exhibit by a member(s) of the association. Top right, "Early Recognition of Oral Cancer" by Dr. Michael E. Jabaley and Robert L. Clement of UMC received the second place member exhibit award, also an engraved plaque. Lower left, "Hinds General Hospital Tumor Conference—Direct Patient Benefits" by Drs. Edward Lowicki, Jack B. Campbell and Charles E. Farmer of Jackson received an honorable mention for member exhibiting. Lower right, "Vascular Trauma" by Drs. Hector S. Howard, H. E. Garrett, J. T. Davis, Jr., and Charles Stewart of Memphis was presented the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember(s).









Top left, Dr. Lamar Weems of Jackson, chairman of the Reference Committee on Rules and Order of Business, reports to the House that a quorum is present and business can begin. Top right, the Speaker of the House, Dr. Walter Simmons of Jackson, presides over the proceedings of the House of Delegates assisted by the vice speaker, Dr. C. D. Taylor of Pass Christian. Below, the association and the woman's auxiliary collected $9,628.91 for the AMA-ERF fund. The check was presented to University Medical Center associate dean, Dr. Carl Evers, by auxiliary president Mrs. W. H. Preston; Dr. Arthur Derrick, MSMA president; and Dr. John McRae of Laurel, Ole Miss Medical Alumni president. Lower left, members of the reference committees meet for breakfast and Dr. Taylor, vice speaker, goes over duties and procedures of the committees.





are president, Dr. James M. Brock of McComb; president-elect, Dr. Louis J. Wise of Jackson; and secretary-treasurer, Dr. Ronald R. Lubritz of Hattiesburg.

Meeting at the coast with MSMA for the first time this year, the Mississippi Society of Anesthesiologists held a dinner program on May 5 at the Sheraton. Officers are president, Dr. Carlos S. Patino of Jackson; and secretary-treasurer, Dr. Katherine A. Aldridge of Hattiesburg.

The Mississippi Neurosurgical Society held a luncheon program on Monday, May 6. Dr. Charles Neill of Jackson is president; Dr. O. J. Andy of Jackson is president-elect; and Dr. Lucien R. Hodges of Jackson is secretary.

Orthopaedic surgeons convened on May 6 for a luncheon meeting. New officers are: president, Dr. James O. Manning of Jackson; vice president, Dr. McWillie M. Robinson of Jackson; secretary-treasurer, Dr. L. Buford Yerger of Jackson; and president-elect, Dr. Sidney R. Berry of Jackson.

State urologists gathered at Biloxi on May 6 for a luncheon meeting. Dr. John P. Elliott, Jr., of Tupelo assumed the presidency. Other officers are Dr. W. Lamar Weems of Jackson, outgoing president: Dr. William C. Gates of Columbus, secretary-treasurer; and Dr. Wafford H. Merrell, Jr., president-elect.

Preceding the section meeting on May 7, the Mississippi Ob-Gyn Society conducted a luncheon. New officers are Dr. Ira E. Gaddy, Jr., of Gulfport, president; Dr. Richard S. Hollis of Amory, vice president; Dr. Kenneth P. Pittman of Jackson, secretary-treasurer; and Dr. Calvin Hull of Jackson, president-elect.





Top left, Dr. Arthur Derrick, 1973-74 MSMA president, addresses the House of Delegates before leaving office. Right, Dr. Derrick is presented the James Grant Thompson Memorial Past President's Pin by Mrs. Thompson of Jackson. Lower right, new president Dr. J. T. Davis of Corinth, at left, is administered the official oath of office by Board chairman Dr. James O. Gilmore. Executive Secretary Charles L. Mathews holds the official association Bible.

The Mississippi chapter of the American College of Surgeons convened on May 7 for a luncheon, scientific session and business meeting. New officers are Dr. Robert S. Caldwell of Tupelo, president; Dr. W. Briggs Hopson, Jr., of Vicksburg, secretary; and Dr. Richard H. Clark, Jr., of Hattiesburg, president-elect.

The Mississippi chapter of the Flying Physicians Association held a cocktail party and dinner on May 7. Dr. Samuel B. Johnson of Jackson was elected president and Dr. Lee H. Rogers of Tupelo is secretary

Family physicians met at a Mississippi Academy of Family Physicians luncheon on May 8. Dr. William B. Hunt of Grenada is president. Other officers are Dr. Thomas J. Anderson of Laurel, president-elect; Dr. Richard T. Furr of Ocean Springs, vice president; and Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer. New officers will be elected at the academy's July 11-13 annual meeting.

A luncheon meeting on May 8 highlighted the annual gathering of the Mississippi Society of Internal Medicine. Dr. Ellis M. Moffitt of Jackson was inaugurated president of the society. New officers elected by the internists are: Dr. James C. Hays of Jackson, secretary, and Dr. A. Robert Dill of Columbus, president-elect.

The Mississippi Eye, Ear, Nose and Throat Association conducted a luncheon and business meeting on May 9. Dr. Patrick L. Pierce of Gulfport is president; Dr. L. Ben McCarty, Jr., of Jackson is secre-





Woman's Auxiliary 1973-74 president, Mrs. W. H. Preston of Booneville, at left, and the new president-elect, Mrs. J. Edward Hill of Hollandale, report to the House of Delegates on the auxiliary's activities for the past year. The new president, Mrs. Dan Reikes of Hattiesburg, was unable to be present but a letter from her was read to House by Mrs. Hill. Below, all living past presidents of the auxiliary were honored at the Tuesday luncheon when the 50th anniversary of the organization was celebrated.

tary-treasurer; and Dr. Daniel H. Moore, Jr., of Meridian, vice president.

The Mississippi Commission on Hospital Care also met during the annual session on Monday, May 6. Dr. H. J. Blakeney of Amory is president and Dr. A. V. Beacham of Magnolia is secretary. Mr. Ernest C. Moss of Jackson is Executive Director.

The Mississippi chapter of the American Academy of Pediatrics hosted a social occasion on Wednesday. Dr. Noel C. Womack, Jr., of Jackson is president.

A Short Course in Practical Tonometry for Non-Ophthalmologists was again sponsored by the Mississippi EENT Association and the Mississippi Society for the Prevention of Blindness.

An all-day Seminar on Family Planning Methodology was held at the Sheraton-Biloxi on Saturday, May 4. The seminar was sponsored by the University of Mississippi Medical Center Division of Family Planning in the Department of Obstetrics-Gynecology.

A half-day postgraduate course, Urology for the Primary Physician, was held on Sunday, May 5, and was sponsored by the Mississippi Urological Society.

Scientific Assembly Begins Work for '75

The 1974 Annual Session is set for May 5-8, 1975, at Biloxi. The Council on Scientific Assembly has already begun planning for the 107th.

Acting by separate sections during the recent 106th Annual Session, the seven components of the Scientific Assembly named new chairmen, and one section elected a new secretary. A new Section on







Anesthesiology was approved at the annual session by the House of Delegates.

Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years. Secretaries of the seven sections are elected on staggered terms.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Named to head the Section on EENT is Dr. Larry H. Day of Hattiesburg. Dr. James W. Rayner of Oxford enters the second year of his three-year term as secretary.

Heading the Section on Family Practice is Dr. Marion L. Sigrest of Yazoo City and the new secretary is Dr. Hardy B. Woodbridge of Jackson.

The internists chose Dr. James C. Hays of Jackson as chairman of the Section on Medicine. Dr. Joe M. Ross, Jr., of Vicksburg enters the second year of his term as section secretary.

Dr. George Ball of Jackson heads the Section on Obstetrics and Gynecology. Entering his final year as secretary is Dr. Charlton R. Vincent of Laurel.

Dr. John Coffey, Jr., of Natchez is the new chairman of the Section on Pediatrics. Secretary Dr. Robert L. Abney, III, of Jackson enters the second year of his three-year term.

Dr. Thomas E. Waller of Starkville will chair the Section on Preventive Medicine. Entering the final year of his term as secretary is Dr. Steven L. Moore of Jackson.

New chairman for the Section on Surgery is Dr. T. Erskine Ross, III, of Hattiesburg. Dr. Henry B. Tyler of Jackson enters the second year of his term as section secretary.

Dr. Carlos S. Patino of Jackson will head the newly formed Section on Anesthesiology and the section secretary will be Dr. Katherine A. Aldridge of Hattiesburg.

Dr. James P. Spell of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly.

Top left, the association fellowship party was held outside by the pools this year and was enjoyed by many members, exhibitors, and guests. Right, new this year was an association-wide membership breakfast on Tuesday morning at the Top of the Sheraton. Below, the auxiliary sponsored an art exhibit of work by doctors and their wives. Pictured are a few of the works on display.









Many of the 15 specialty societies meeting concurrently with the MSMA annual session elected officers. Top left, new president of the American College of Surgeons, Mississippi chapter, is Dr. Robert S. Caldwell of Tupelo, center. Other officers are Dr. Richard H. Clark of Hattiesburg, at right, president-elect, and Dr. W. Briggs Hopson, Jr., of Vicksburg, secretary. Top right, officers of the Mississippi Association of Pathologists are from left, outgoing president, Dr. George F. Smith of Jackson; president-elect, Dr. Van Philpot, Jr., of Houston; and treasurer, Dr. Larry Smith of Hattiesburg. Lower left are shown the officers of the Mississippi Ob-Gyn Society, from left: Dr. Calvin Hull of Jackson, president-elect; Dr. Ira E. Gaddy, Jr., of Gulfport, president; and Dr. Kenneth P. Pittman of Jackson, secretary-treasurer. The Mississippi Society of Internal Medicine's new officers are, from left: Dr. James C. Hays of Jackson, secretary and MSMA section chairman; Dr. Ellis M. Moffit of Jackson, president; Dr. Joe Ross of Vicksburg, section secretary (MSMA); and Dr. A. Robert Dill of Columbus, president-elect.





Dr. Spell said, "The council will be meeting this summer to review preliminary plans for the 107th Annual Session and to begin actively working on the program."

He said that the exhibit prospectus for technical exhibitors will be released this fall. Specialty socicties arc invited to submit plans for concurrent meetings and requests for assignment of rooms, including those for meal occasions, he added.

The president, Dr. J. T. Davis of Corinth, and the president-elect, Dr. Jack A. Atkinson of Brookhaven, are *ex officio* members of the Council on Scientific Assembly under the By-Laws.

Urologists Elect Officers At Annual Session



The Mississippi Urological Society meeting at Biloxi resulted in the following new officers: Dr. William C. Gates of Columbus, at left, secretary-treasurer; and Dr. W. H. Merrell, Jr., of Jackson, president-elect. New president, Dr. John P. Elliott of Tupelo, was not present when pictures were made.

Acupuncture Fails to Cure Deafness

Acupuncture failed to cure nerve deafness in a carefully controlled scientific study at Michigan State University, says a report in the April issue of *Archives of Otolaryngology*, a publication of the American Medical Association.

The use of acupuncture for ancsthesia and as treatment of a number of ailments has attracted the attention of both the public and the medical community in recent years. Within the past two years an increasing number of hearing-impaired patients have becn undergoing acupuncture trcatments. Several earlier studies had tentatively reported some success.

The research group at Michigan State brought in a trained acupuncturist with 15 years experience to treat an ex-serviceman deafened by firing weapons in combat in World War II. He was given cight treatments at one-weck intervals. His hearing was measured scientifically with a battery of audiological tests before, during and after thc treatments.

There was no evidence that the acupuncture treatments resulted in any measurable change in the patient's sensorineural hearing loss, the researchers report.

The study was by William F. Rintelmann, Ph.D., Herbert J. Oyer, Ph.D., Janis L. Forbord, and Phyllis L. Flowers, of the Department of Audiology and Speech Scicnces at Michigan State, East Lansing.

Non-Tobacco Cigarets Are Hazardous to Health

Cigarets of dried lettuce or grass are just as damaging to the respiratory system as thosc of tobacco, says a report in the May issue of *Archives of Environmental Health*, a publication of the American Medical Association.

"Grass" in the research report is Kentucky bluestem, not marijuana.

A research pair at the University of Tennessee, Knoxville, used commercially prepared lettuce cigarets and cigarets which they made in the laboratory from grass in an effort to determine whether the non-tobacco products would be safe, or less harmful.

They found that the adverse effect on the respiratory system's defense mechanism was just as bad for the non-tobacco cigarets as from thc genuine article.

They concluded that smoke from any burnable material will cause respiratory damage. In one aspect of the study, they used purified nicotine to see whether it was involved in the respiratory damage. They found that it was the smoke, not the nicotine, that was at fault.

The study is by John P. Gray, M.S., and John R. Kennedy, Ph.D., of thc University's department of zoology.

Board of Trustees Names 1974-75 Officers

Two new names appear on the roster of the association's governing body, the Board of Trustees. Elected for three-year terms by the House of Delegates were Dr. Arthur A. Derrick, Jr., of Durant, representing District 4, and Dr. Joe S. Covington of Meridian, representing District 6.



Dr. Gilmore

Dr. Carl G. Evers of Jackson was re-elected to a three-year term from District 5.

Dr. James O. Gilmore of Oxford, District 2, was re-elected Board chairman. Dr. Gerald P. Gable of Hattiesburg is secretary and Dr. Everett Crawford of Tylertown is vice chairman. The chairman, vice chairman and secretary make up the Executive Committee.

Continuing to serve are Drs. Lyne S. Gamble of Greenville, District 1; Robert S. Caldwell of Tupelo, District 3; and James T. Thompson of Moss Point, District 9.

Retiring from the Board were Drs. Paul B. Brumby of Lexington and Guy T. Vise of Meridian.

Eight general officers meet with Board. They are the immediate past president, president, president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker and the AMA delegates.

Emory M.S. Center Gets $800,000 Grant

Emory University has been awarded a grant of $800,000 for the support of a Center for Research in Multiple Sclerosis and Related Diseases.

The award is from the National Institute of Neurological Diseases and Stroke and covers a four-year period which began Feb. 1.

The Emory center is one of three in the United States, the others being at the University of Pennsylvania in Philadelphia, and the University of California at Los Angeles.

Dr. Herbert R. Karp, chairman of the Division of Neurology, Emory University School of Medicine, said the new center makes it possible for investigators from many different scientific disciplines to continue Emory's active research program in multiple sclerosis.

Dr. Robert F. Kibler, member of the Emory faculty since 1962, is director of the new center. Principal investigators working with Dr. Kibler include Dr. Raymond Shapira of the Department of Biochemistry, who together with Dr. Kibler has isolated and synthesized a protein which can produce a multiple sclerosis-like disease in experimental animals.

Dr. Dale E. McFarlin, neuroimmunologist, and Dr. David L. Camenga, neurovirologist, are actively investigating the concept that viruses in combination with the immune and inflammatory responses of the body may be responsible for diseases such as multiple sclerosis.

"Emory has been building toward the research center concept for several years," Dr. Karp said. "Financial support from the National Multiple Sclerosis Society and private sources has made this research possible. The present award from the Department of Health, Education and Welfare is a most gratifying recognition of the quality and importance of our research."

Better Day Care Centers Sought by AMA

Parental care for children in their own home is better than day care of children in a center away from home, but if day care becomes necessary it should be good care, says a new statement of the American Medical Association's Committee on Maternal and Child Care.

Today, great numbers of children are receiving day care of a widely variable quality, often unlicensed and unregulated, the committee statement declares.

"The committee, concerned with the physical and mental health and development of all children, is supportive of well qualified, critically licensed, and regularly monitored day care centers. While the committee is convinced that parental care is generally to be preferred for optimal performance as adults, children require nurturing, security and supervision

not always available in the home, especially when both parents work outside the home."

Mere custodial care is unacceptable, the statement says. Competence at every level, maintained by ongoing education and training for staff members, can offer children enrolled in day care an opportunity for optimal achievement.

The centers should be readily accessible, properly staffed, have parents involved, have proper health and safety services, be able to handle individual needs of children, and have activity programs of good quality.

Charges for day care services should be set according to a family's ability to pay, and in certain cases the cost should be subsidized by a third party payer. The centers must involve parents if they are to supplement the child's home experiences effectively. The "curriculum" should permit each child to advance at his own pace.

The facility, whether large or small, must be safe, adequate in living space and appropriately equipped to serve the interests and needs of children of variable ages.

Dr. Russell P. Keith of Los Angeles is chairman of the AMA committee.

Warning Voiced on Use of Menstrual Extraction

Menstrual extraction—a technique now widely used for early termination of pregnancy—is not a casual procedure and should be done only when tests have definitely confirmed pregnancy, says a report in the May 13 issue of the *Journal of the American Medical Association.*

"The administration of medical or surgical treatment prior to establishment of a diagnosis is considered poor care," says the report by Dr. Jane E. Hodgson, and Roxanne Smith and Daniella Milstein of the Preterm Clinic, Washington, D. C.

"Justification for performing uterine evacuation simply because a woman experiences a delayed menses has not yet been demonstrated," the authors say.

"Women's liberation groups pounced on the concept of menstrual extraction, viewing it as a means of better controlling their own destinies and ending male authority. A number of enthusiastic women's groups began performing so-called 'extractions' on each other—at monthly intervals, if necessary.

"Self-diagnosis and self-treatment are risky matters. The evacuation of a nonpregnant uterus may be a difficult matter. Two outstanding advocates of menstrual extraction have now reverted to recommending preliminary pregnancy testing."

A common complication of the procedure is incomplete evacuation of the uterus. One researcher reported a continuing pregnancy rate of 5 per cent when using a particular type of equipment commonly utilized among the women's liberation groups, the authors said.

In their own clinic, they said, most women were willing to await tests confirming pregnancy before undergoing extraction, once they were assured that abortion would be available to them if and when it is indicated. Of one small group of women who insisted on immediate extraction before pregnancy was confirmed, one suffered a uterine perforation from the inserted tube, and another has since been under treatment for uterine bleeding.

The authors frowned on the process of untrained, or partially trained, individuals performing extractions, pointing out that "the evacuation of a nonpregnant uterus may be a difficult procedure."

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State Narcotics Bureau Needs M.D. Cooperation

The Mississippi Bureau of Narcotics has more responsibility than just the arrest of drug offenders according to Director Kenneth W. Fairly. In an effort to educate the public to the scope of duties of the bureau, Fairly pointed to three sections of the Uniform Controlled Substances Act as amended by the 1972 session of the Legislature:

Section 41-29-159 (d)—"Agents of the bureau are hereby authorized to investigate the circumstances of deaths which are caused by drug overdose or which are believed to be caused by drug overdose."

Fairly said, "Usually it is the work of the pathologist to determine what drugs may have been used in an overdose, but in some instances the bureau will develop leads which will lead to the prosecution of people who have sold the drugs to the deceased."

Section 41-29-159 (e)—"Any person who shall impersonate in any way the director or any agent, or who shall in any manner hold himself out as being, or represent himself as being, an officer or agent of the Mississippi Bureau of Narcotics shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not less than one hundred dollars ($100.00) nor more than five hundred ($500.00) or by imprisonment for not more than one (1) year, or by both such fine and imprisonment.

Arrests have been made for this offense with one subject now confined to a mental institution.

Section 41-29-168 (2)—"The owner, manager, practitioner, or any other person having possession or custody of controlled substances or of premises on which controlled substances are stored or located, whether or not such person is a registrant under section 41-29-125, is hereby required to report to the bureau any theft, burglary, robbery or ATTEMPTED THEFT, BURGLARY or ROBBERY of such premises or substance, or the mysterious disappearance of any controlled substance within 48 hours of the discovery of such occurrence or disappearance.

Fairly said, "We need to inform all physicians, pharmacists, and other people in possession of controlled substances to report their loss by burglary or armed robbery within a 48 hour time period. We are not getting 100 per cent reporting from all persons in legal possession of controlled drugs and narcotics."

The main purpose of the Mississippi Bureau of Narcotics is to detect and apprehend the illicit drug dealer, but the total responsibility of this agency encompasses a wider spectrum of the drug problem in Mississippi.

University Increases Freshman Class to 150

The University of Mississippi School of Medicine freshman class will increase to 150 this fall, 28 over 1973 and 60 more than just five years ago.

Anticipated total medical school enrollment in 1974 is 487 compared to 330 in 1969, said Dr. Norman C. Nelson.

Vice chancellor for health affairs and dean of the School of Medicine at the Medical Center in Jackson, Dr. Nelson said the school is making this latest, longest step up in freshman class size "in response to the state's documented need for more physicians."

Dr. Nelson said the school had asked the accrediting Liaison Committee on Medical Education to support the major expansion in March, pointing to the "remarkable increase" in state support for the school since the 1969 accreditation inspection as proof of "Mississippi's willingness to support health education."

The substantial increases in Medical Center appropriations for 1974-75 were key factors in the committee's approval, Dr. Nelson stated. The committee, comprised of Association of American Medical Colleges and American Medical Association representatives, looks at a school's applicants, faculty, facilities, and financial base before authorizing expansion, he explained. Approval was "directly contingent upon added financial support," he said, and the state government met that challenge.

"As a public institution and the only academic health sciences center in Mississippi, we feel an imperative duty to respond to this kind of support by enlarging our enrollments as rapidly as can be achieved without jeopardy to quality," he said.

The 1974 increase will be the seventh in nine years. Entering enrollment stayed near 80 for the first 10 years after the school moved from Oxford and became a four-year program in 1955.

Flying Physicians Hold 20th Annual Meeting

The Broadwater Beach Hotel at Biloxi will be the setting for the 20th annual meeting of the Flying Physicians Association, Sept. 22-27, 1974.

Many of the flying doctors will pilot their own aircraft to the nearest airport, Gulfport, where transportation to the meeting will be provided through the courtesy of the Broadwater Beach Hotel. Tiedown facilities and parking space will be required for as many as 300 aircraft. Also required will be an area large enough for the static display of the latest aircraft.

Chairman of the scientific program for this year's meeting is Dr. Roy C. Page, Memphis. Assisting him will be the following doctors: Horace K. Sawyer, Jr., Atlanta; Edwin W. Lauterbach, Meadowbrook, Pa.; Donald B. Frankel, Chicago; John W. Sabatine, Sands Point, N. Y.; William H. Keen, West Vancouver, British Columbia; Richard C. Schaeffer, Redondo Beach, Calif.; Lynwood M. Hopple, Aurora, Colo.; Ephriam B. Wilkinson, Jr., Memphis; and Elvin Dean Thompson, Jefferson, Iowa.

Dr. Page and his committee have chosen as this year's theme: "Medical Aspects of Aircraft Accidents." They have further divided this main theme into four sub-themes: 1. Psychological Aspects of Aircraft Accidents; 2. Organic Illnesses; 3. Medical Aspects of Aviation Training; 4. The Pilot and His Machine—Human Factors.

Also part of the scientific program will be a Monday evening of round-table discussions on the following: Engine Maintenance, IFR vs. VFR, Weather, TCA Operations and New FAA Regulations, Ladies in Flight. One afternoon will be devoted to a Tax Seminar.

On Wednesday night, the entire program will be devoted to a "Product Profile" session during which the exhibitors will be given the opportunity to discuss their latest products.

In charge of local arrangements for the meeting is Dr. Curtis W. Caine, Jackson. Members of his committee include the following doctors: Donald B. Frankel, Chicago; Jack A. Stokes, Pontotoc; Charles H. Heywood, Canton; Hewitte A. Thian, New Orleans; Horace K. Sawyer, Jr., Atlanta; Jim C. Barnett, Brookhaven; John G. Caden, Max L. Pharr, James L. Royals, and Samuel B. Johnson, all of Jackson.

Founded in 1954, the Flying Physicians Association has grown from a membership of 700 members to its present size of 2400, including members in Australia, the Bahamas, the Barbados, Canada, Colombia, the Dominican Republic, England, Israel, Kenya, Malawi, Mariana Islands, Morocco, Puerto Rico, Rhodesia, Trinidad, the United States, the Virgin Islands, West Germany, Venezuela, and the Republic of Zaire.

Membership is open to all medical doctors who are members of medical societies approved by the FPA's Board of Directors, and who hold valid pilot certificates. For information and an application write to: Mr. Albert Carriere, Business Counsel, Flying Physicians Association, 801 Green Bay Road, Lake Bluff, Ill. 60044.

Hamsters Are Linked With Meningitis

A number of recent federal reports links occurrences of lymphocytic choriomeningitis with the keeping of pet hamsters, according to Dr. Durward Blakey, director of Disease Control, State Board of Health.

Dr. Blakey indicated that a recent report from the Department of Health, Education and Welfare said that hamsters associated with the human infections have been distributed by a New Jersey firm.

The report says that stores in Mississippi to which this company distributes are Woolworth, Kresge, Grant, McNew, Murphy, Ben Franklin, TG&Y, Sterling, Kuhn Brothers, Rose, Elmore, Gibson, Walkers, and Magic Mart.

Dr. Blakey said that persons with a history suggestive of LCM and owning hamsters purchased at these businesses between Dec. 4, 1973, through Mar. 22, 1974, should immediately destroy the hamsters through appropriate facilities such as animal shelters.

Stores should make certain that all bedding, litter, water bottles, cages, and other materials in contact with hamsters acquired from the implicated shipments should be destroyed or decontaminated.

Persons desiring more information should contact their local health department.

Top Heart Experts Confer at UMC



Dr. Tetsuzo Akutsu, center, shows his model of the artificial heart at the University Medical Center to Dr. Clarence Dennis of the National Heart and Lung Institute, left, and Dr. Valeriy I. Shumakov, right, who heads the Russian transplant and artificial heart program in Moscow. Dr. Dennis arranged the meeting between two of the world's foremost artificial heart researchers. The Russian surgeon heads a program which has transplanted 100 artificial hearts in calves, the experimental animal also used at the Medical Center. The scientists were agreed that a temporary artificial heart which will sustain life for a few days in man is not too far away—maybe a year or two. But any hope of something permanent, a man-made heart to replace a worn-out pump, is many years off, in Dr. Shumakov's words. This is Dr. Shumakov's third visit to the United States, but his first to Mississippi. The eminent Russian surgeon is ahead of U. S. doctors in some areas of research, while U. S. researchers continue to set the records for success in sustaining life using artificial hearts.

Odyssey House Opens Louisiana Branch

Odyssey House of Louisiana has been opened at 1125 North Tonti Street, New Orleans, for the treatment and rehabilitation of drug addicts. It is one of 33 treatment facilities in six states: Michigan, New Hampshire, New Jersey, New York, and Utah.

The philosophy underlying the program is that drug addiction is a symptom of a self-destructive psychologic disorder. Therefore, to cure the addict his personality must be restructured so that conventional personal growth replaces drug dependency. This is best done in an in-residence therapeutic community wherein no substitute drugs are used; absence of drug use is assured by witnessed urine screening three times a week, and there is continuing supervised open-group confrontation among residents that forces them to face the reality of themselves, their peers and their environment.

Duration of treatment is 18 months under the supervision of a staff which is 50 per cent professional and 50 per cent trained ex-addict graduates.

Odyssey House claims that 98 per cent of its graduates remain drug-free and points to their $12,000 average yearly income as evidence of their total rehabilitation; they further state that 85 per cent of those who leave the program against medical advice after only 6 months of treatment remain drug-free.

There is no charge for the treatment, practically all support is generated from outside sources.

No one is refused induction—there is always room for one more.

For further information about the program telephone (504) 821-9211; ask for Mrs. Margaret Pike, R.N., or Frank Lemons.

UC-Berkeley Offers Maternal-Child Program

The Maternal and Child Health Program at the University of California School of Public Health at Berkeley announces postgraduate courses of instruction for pediatricians, obstetricians, and other physicians interested in receiving training in the field of maternal and child health. These programs all lead to the degree of Master of Public Health. Tax-exempt fellowships are available, consisting of support for the trainee and his dependents, tuition and fees.

Program areas at the present time include nine-month programs in Maternal and Child Health, Day Care and the Preschool Child, Health of School-Age Children and Youth, and Maternal Health and Family Planning. Twenty-one month programs in Care of Handicapped Children, Comprehensive Health Care and Perinatology are also available.

Applications are now being accepted for the group entering September 1975. For information, write to Dr. Helen M. Wallace, School of Public Health, University of California, Berkeley, Calif. 94720.

UMC Animal Research Facilities Improved

University Medical Center has been awarded a grant to improve its laboratory animal facilities.

The grant—$104,569—was awarded through the DHEW's Animal Research Branch in the Division of Research Resources.

"For superior research results, research animals must be kept in optimum conditions," said Dr. Russell Christie, director of the UMC's laboratory animal facilities.

The Medical Center began upgrading animal resources in 1967 when it established the laboratory animal facilities and hired Dr. Christie, a veterinarian experienced in laboratory animal medicine, as director.

An American Association for Accreditation of Laboratory Animal Care site visit in 1969 led to UMC's provisional accreditation. According to Dr. Christie, the recent HEW grant will enable the Medical Center to meet full accreditation standards.

The Medical Center's laboratory animal facilities have had an important part in Mississippi's scientific contributions to new knowledge. Such medical advances as the world's first transplant of a heart into a human and the world's first lung transplant were made possible through research conducted in the animal laboratory facilities.

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AMA Recruits Doctors for Shortage Areas

The American Medical Association has agreed to begin recruiting mid-career physicians for two-year assignments in the National Health Service Corps (NHSC).

This is one of several new or expanded functions spelled out in the NHSC's second contract award to Project USA, an AMA-sponsored enterprise that has been working with the Corps since late 1972.

The new contract, retroactive to last Dec. 31, runs through June 1975.

The NHSC is a federal program that places physicians and other health professionals in areas of critical need, urban as well as rural. Corps volunteers generally serve about two years, though some elect to settle permanently in their assigned communities.

Up to now, Project USA has helped the Corps find short-term replacements for NHSC physicians who leave their assigned communities to take vacations or pick up postgraduate educational credits. Working from a pool of several hundred potential volunteers, the project has filled 52 vacancies to date.

The short-term recruiting function will continue, with physician volunteers now financed directly by Project USA rather than the federal government. Under the new contract, Project USA also will become involved in long-term recruiting.

The Corps traditionally has attracted young physicians, those just out of residency or just out of the military. But apparently there is feeling that some older physicians, already established in practice, might also be willing to accept the challenge of a two-year minimum commitment.

These may be physicians who are looking for a change in life style, but who are reluctant to build a new medical practice from scratch.

Plan now to attend

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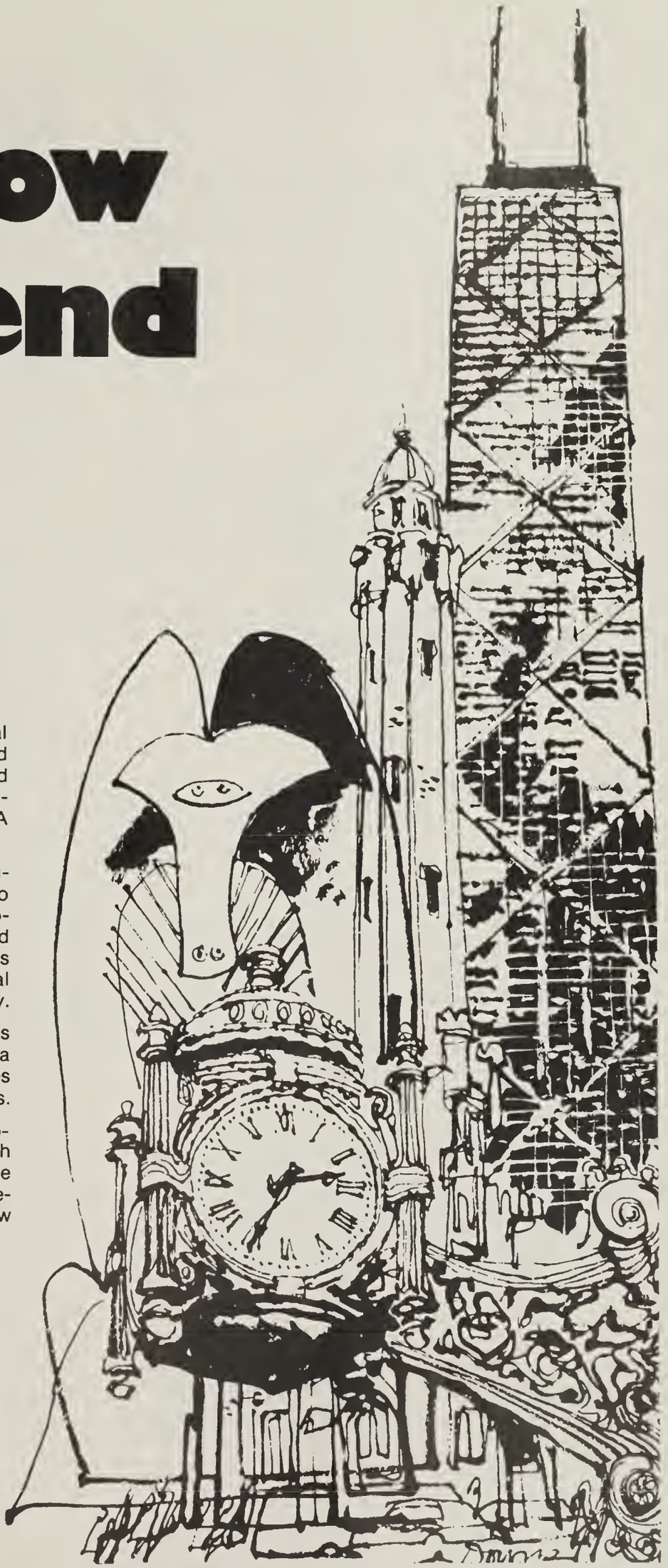
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Scientific Exhibits. . .featuring Clinical Pathologic Conferences/Live Teaching Clinic/Fresh Tissue Pathology. View or actively participate in these and over a hundred other exhibits designed to keep you knowledgeable about new techniques in your field.



Miss. Medical Group Mgr. Association Meets

The initial quarterly meeting of the Mississippi Chapter of the Medical Group Management Association is scheduled for Wednesday, Aug. 28, 1974, at Holiday Inn North in Jackson.

The program will begin at 9:00 a.m. and end with a "Dutch treat" luncheon.

Administrators of the practice of three or more licensed physicians sharing common facilities and actively engaged in practicing medicine are qualified for membership in the organization which includes 1500 medical clinics in the U. S. and Canada.

For details contact John W. Gill, 656 North State Street, Suite 165, Jackson 39201, telephone 601-354-3330.

Interstate Assembly Set for Fall

The 59th Annual International Scientific Assembly of the Interstate Postgraduate Medical Association will be held at The Diplomat Hotel and Resort, Hollywood, Fla., Nov. 3-7. This program, primarily designed for primary physicians in the U. S. and Canada, has been planned cooperatively with the Florida Academy of Family Practice and the University of Miami School of Medicine. It will provide 26 hours of *prescribed credit* for A.A.F.P. members who attend.

The program will consist of lectures, informal group discussions, medical movies and symposia on a variety of topics, with major emphasis on pediatrics, internal medicine, cardiology and psychiatry related to office practice. Guest lecturers include Drs. Fletcher Derrick, Charleston, S. C. (Urology); E. S. Gordon, Madison, Wis. (Endocrinology); William A. Long, Jackson, Miss. (Pediatrics); William P. Longmire, Los Angeles (Surgery); Noel Mills, New Orleans (Vascular Surgery); C. Thorpe Ray, New Orleans (Internal Medicine); and James W. Wilson, Durham, N. C. (Pathology). An additional 35 teachers from Miami and Gainesville, Fla., will instruct at the assembly.

The assembly is open to any licensed M.D. in the U. S. or Canada at a fee of $35 in advance or $50 at the meeting. Those interested in full details of the meeting and hotel forms should write to: Dr. Alton Ochsner, Program Chairman, Interstate Postgraduate Medical Assn., P.O. Box 1109, Madison, Wis. 53701.

The Nurse and the Law Workshop Held

The nurse and the law was the topic for the second workshop coordinated by the newly-appointed University of Mississippi School of Nursing alumni continuing education committee.

The workshop, held May 1 and 2 at the University Medical Center in Jackson, featured discussions with four experts in the fields of both law and medicine.

Belhaven graduate Ms. W. Ann Hopper took up responsibilities and rights of nurses. Currently enrolled in the Jackson School of Law, she has special interest in medical law.

Cary Bufkin, a Jackson attorney, reviewed how the law affects nurses. The University of Mississippi graduate is a member of the Federation of Insurance Counsel and the International Association of Insurance Counsel. He discussed malpractice insurance and case reports in Mississippi.

Other workshop leaders were Ms. Jeannette Gray, executive director of the Mississippi Board of Nursing, and Dr. Paul Derian, UMC professor of orthopedic surgery and adjunct professor of law in the University of Mississippi School of Law.

The seminar, with support from the University of Mississippi nursing alumni chapter, the University Medical Center Continuing Education Committee, University Hospital Nursing Service, the School of Nursing and the Mississippi Regional Medical Program, was the second of a series of educational and training programs the committee plans for 1974.

CLASSIFIED

General Practitioner needed to replace loss in rural community. For information on this excellent opportunity, contact the Administrator, Smith County General Hospital, P.O. Box 337, Raleigh, Miss. 39153, phone 782-4281.

WANTED—Full-time Medical Director for Mississippi's largest health care insurer. Interesting and challenging position. Duties include both inside and outside activities. For further information, contact Mr. W. C. Mosely, Blue Cross and Blue Shield of Mississippi, Inc., Jackson, Mississippi, 366-1422.

Immediate opening for primary care physician in N.E. Mississippi city of 30,000. Salary @ $30,000/annum + liberal fringe. Option to assume operation as private practice can be negotiated. Contact: Craig Clark, Director of Primary Health Care, 601/844-5637, Professional Bldg., Suite 420B, Tupelo, MS 38801. An Equal Opportunity Employer.

WANTED: Internist or family practitioner to replace loss in clinic. Contact Long, Dees and Edwards Clinic, 775 North State Street, Jackson, Miss. 39201. 601-352-0753.

GENERAL PRACTITIONER, INTERNIST OR GENEAL SURGEON to serve as Outpatient Physician, including admissions. New VA Hospital with active teaching and residency program. Salary based on qualifications according to VA Salary scale. 40 hour basic work week. Liberal fringe benefits. Non-discrimination in employment. Write Chief of Staff, VA Center, Jackson, Miss. 39216.

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IN CONCLUSION

An individual tablet or capsule of prescription medicine cost the consumer, on average, 2.3 per cent less in 1973 than in 1971 - and 6 per cent less than in 1960 - encompassing a period of acute inflation in the general economy, according to a report by the Pharmaceutical Manufacturers Association. In a related analysis PMA studied the working time required for the average employed person to earn the cost of a prescription: a non-farm worker with 3 dependents worked 32.4 minutes in 1973 to earn the cost of the same quantity of prescription drugs it would have required an hour in 1960.

"The Family - Hope of the Future" will be theme of a public program to be sponsored by the AMA June 23 in conjunction with the annual convention in Chicago. One of the few events of the annual physicians' convention that is open to the public, the program will be presented in the Palmer House at 8:00 p. m. under sponsorship of the AMA's Department of Medicine and Religion. The meeting will be open to physicians, clergy and their wives, and to the general public. Speakers will focus on destructive elements in the family relationship that tend to produce problem children.

During the 10 years prior to 1968 one single strain of influenza caused a 3 year pattern of severe, moderate and mild flu seasons. In 1968 a new strain, influenza A/Hong Kong/68, became prominent causing 3 severe seasons. In 1972-73 influenza A/England/72 caused a second record breaking year. According to the Center for Disease Control, isolated outbreaks of an influenza B strain have been recorded in some areas of the U. S. during the 1973-74 flu season. From 1968-1972 NDTI recorded an average of 768,000 monthly visits to private practitioners for flu.

California women seeking marriage licenses now must be immunized against rubella. A new law requiring immunization of women under 50, except those who can prove immunity or who are sterile, went into effect in March. The law was originally passed by the state legislature in 1972 and was scheduled to take effect in March 1973, but a lack of laboratory facilities in many counties forced delay for a year. California is now the only state with such a requirement. State Department of Health advocated law to help prevent birth defects in children born to infected mothers.

Among males, accidents are the leading cause of death at ages under 35, accounting for over half the deaths in the age range 5-24, says the Metropolitan Life Insurance Company. Suicide is a leading cause of death among younger men and cardiovascular-renal diseases are the main cause of death at ages 35 and over. Cancer causes more than one fifth of all male deaths in the age range 45-74. Among females, accidents led under 30 and cancer in the age range 30-59. Cardiovascular-renal diseases did not become the leading cause of death in women until ages 60 and over.

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SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "CPC," Clinicopathological Conference; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; the asterisk (*) indicates an original article in the JOURNAL, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M" respectively.

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